MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Embassy Suites Hotel
1250 22nd Street, N.W.
Washington, D.C.

Thursday, December 9, 1999
10:19 a.m.

COMMISSIONERS PRESENT:

GAIL R. WILENSKY, Ph.D., Chair
JOSEPH P. NEWHOUSE, Ph.D., Vice Chair
BEA BRAUN, M.D.
PETER KEMPER, Ph.D.
JUDITH R. LAVE, Ph.D.
DONALD T. LEWERS, M.D.
HUGH W. LONG, Ph.D.
FLOYD D. LOOP, M.D.
WILLIAM A. MacBAIN
JANET G. NEWPORT
CAROL RAPHAEL
ALICE ROSENBLATT
JOHN W. ROWE, M.D.
GERALD M. SHEA
MARY K. WAKEFIELD, Ph.D.

AGENDA PAGE

P R O C E E D I N G S [10:19 a.m.]

DR. WILENSKY: It's appropriate to lead our discussion off with quality.

MS. DOCTEUR: This paper is a follow-up to the discussion that you had last month, to begin to talk about quality monitoring in Medicare post-acute care systems. This paper specifically was designed to assess Medicare's capacity to monitor post-acute care quality. It sets forth three types of ways in which you might want to do that, and looks at where we stand in terms of being able to do that in Medicare right now.

The three things that we looked at are the ability in Medicare to evaluate quality of care in specific post-acute care sites, like home health and skilled nursing facilities. We concluded that current capacity is limited. Things are now getting underway but comparing, for example, home health and skilled nursing facilities, we really see a lot of differences in terms of the objectives that have been set up, the types of data that are being used, the nature of

the measures that are being used, and then the progress in actually implementing those systems.

The second thing that you might want to develop the capacity to do in Medicare is then to compare quality across different post-acute care settings. The paper concludes here that there is some future potential to be able to do this but it's limited in certain respects, and we'll talk about this.

And third, the paper puts forth the idea that you might want to be able to assess quality of care in a post-acute care episode that involves multiple post-acute care providers. This would involve, for example, looking at the outcomes for beneficiaries, for example, who might have had a stroke and had received care in multiple sites. The paper concludes that if this is a direction that you did want to move, this would require significant redirection in terms of what we're doing now.

Let me begin with an overview of the paper's findings on the SNF care quality monitoring status. First

of all, the current objectives that have been articulated by both the Congress in the BBA and by HCFA are to set up a system designed to evaluate the effects of PPS changes. And then HCFA has gone beyond that to say, in addition, that it would like to use the quality monitoring system it set up to both improve the quality assurance program right now through the survey and cert agencies, and also to establish a new quality improvement program for SNF care.

The data and the quality measures are issues that are raised in this paper, primarily in that there are some concerns about the utility of the data on the quality measures. They were developed for long-term care and HCFA's in the process of testing whether they also are applicable for skilled nursing facility care. There are some other concerns related to the data that are discussed in the paper.

So then the issues that we would ask you to discuss today, related to SNF quality monitoring, you want to first ask the question whether existing objectives that

have been articulated can be met using the existing methods in the data. And second, do you want to expand the monitoring objectives from what has been clearly articulated at this point?

Moving on to home health, we see a somewhat different picture. In this case, we don't have a situation in which the Congress has set up any particular objectives for home health care quality monitoring. At the same time, HCFA has had a program that's been in development for a number of years now, which now they're starting to set it up, they've tested it.

In this system, HCFA has articulated three objectives at this point. In the short term, they're interested in improving their quality assurance program through the OASIS. Also, similarly to the SNF, they're interested in establishing a quality improvement program for home health. And finally, HCFA said in the future they're interested in providing some consumer information on their website.

The data again on the quality measures is very different here. We see OASIS, a data system that was designed for outcomes measurement, and we're using some outcomes measures that were specifically designed for this purpose.

The issues, I think, that would be useful for commissioners to discuss here again relate to whether you want to specify expanding any monitoring objectives. One that's put forward for your consideration is whether you want to specifically ask HCFA to assess the effects of the prospective payment system on quality. This hasn't been something that the Congress has called on them to do, and this hasn't been something they've said they planned to do.

The second question then is the question of whether you want to ask that Medicare invest in quality measures that are designed to evaluate beneficiaries' use of needed services. Right now, the OASIS outcomes measures focus on outcomes of care. And if you have concerns about underutilization of needed care under the PPS, you might

want to consider looking for some normative standards that can be translated into quality measures for home health.

Quickly on the rehab facility care quality, at this point no objectives for the Medicare quality monitoring for rehab facility care has been articulated. At this point, HCFA's not collecting any patient assessment data and the paper discusses where we might be going ahead with this in the future.

Commissioners might consider whether we want to postpone talking about this in detail until HCFA's put forth something, perhaps in the PPS rule. Or if we wanted to talk about it now in general terms, in terms of what objectives should be set forth when the system comes out or what types of data are we interested in having them collect.

Moving on to the question of why we might want to move beyond site specific quality monitoring, the paper discusses two different objectives that you could have in thinking about why you'd want to do this. First, you might want to be able to compare quality care in different

settings. Second, you might want to be able to again, evaluate post-acute care episodes that involve multiple providers.

If you wanted to pursue these two objectives, the paper lays out some things that you might want to think about that you would need. First, common core data elements and quality measures would be needed to compare across sites. And then, if you wanted to move to the second objective of the episode-based quality monitoring, you would probably want to move beyond that to some sort of a coordinated data collection effort. That could be an iterative data collection based on the patient, as opposed to provider-oriented. And also, some cross-cutting quality measures that utilize data from different sites.

Next, the paper talks about some other factors that you would want to think about in deciding whether you wanted to pursue these two types of objectives or not. I think one factor obviously is the need to obtain information to run what we have right now as highly disparate payment

systems. This argues for under the current system you're not going to be able to have completely identical data collection efforts.

Second, you want to think about, in the future, accounting for cross-site service substitution potential and what sort of incentives you set up as you differentiate these data collection efforts.

Third, I think the Commission has articulated a strong sense that there's interest in limiting the data collection burden that's experienced both by providers and by patients.

And then finally, thinking in the future again about interest in integrating post-acute care payment and delivery through bundling or through some sorts of new delivery systems.

Concluding with some issues for discussion that we'd like to see the Commission discuss relating to this cross-sites quality monitoring issues, first some questions relate to Medicare's post-acute care quality monitoring

efforts. We ask you to consider whether you think it makes sense to have common objectives for monitoring across different sites of service. We don't see that now.

Would you like to also include -- and here you can choose one or more -- do you want site specific quality monitoring? Do you want to do comparative monitoring across different sites? And/or do you want to move to an integrated measurement system in the future at some point?

The next set of questions for discussion relates to Medicare's post-acute care data collection efforts. Some of these seem quite straightforward, but some others are not. One thing you might want to consider is whether Medicare's post-acute care data collection efforts should be limited to items that are needed for payment and quality measurement, not for care planning, for example.

I think this is key because right now across the different sites, as discussed in the paper, we've got situations where we've got an MDS that has 300 items, many of which are not used for either quality monitoring or

payment. We've got the OASIS with 79 items and, again a subset are used for those things. And thinking about whether it makes sense to have HCFA collect more than what is needed for quality and payment I think is an issue.

Another question for consideration is do we want to move to common data items where possible? Again, the paper raises some questions about the comparability of existing items.

A further question is do we want to include site-specific data where it's needed, but to ensure some commonality of definitions, terms and response codes even where specific items might differ to help with integration of data in the future?

A final question that I think really is not straightforward and should be subject to some consideration is whether or not you want to think in the future about integrating data collection efforts across service sites. This would involve not just using core data but perhaps thinking about things in the future, like common data

repositories, consistent data collection practices or iterative data collection tools.

DR. WILENSKY: Beth, do you want us to go back to the issues for discussion and do these one by one?

MS. DOCTEUR: That would be helpful.

DR. WILENSKY: If people want to make overall comments first, that would be fine, about what was in this material.

DR. LAVE: I wanted to make an overall comment and that is that I was both impressed and distressed by this chapter. I was impressed with what was in it and I was distressed by the fact that the data collection efforts in the long-term care area appear to be disjointed in a way that one would wonder whether or not that's necessary.

So as I read this, I couldn't understand, for instance, why it was that you would have three data sets that collected data on bathing, and nobody decided that there was one way that we would ask for that kind of information.

The other thing that struck me, as I looked at this question, since this seemed to be a data question, was some of the warnings that we had last time when we were talking about changing the data collection when we were talking about the case-mix data for hospitals. And everybody sort of warned if you add one column to a data collection instrument, in fact, it is very costly.

So what I wonder, when we think through this, is that I think that it's very useful to try to think about a long-term strategy that would make sense with data across settings that would be similar. I just can't imagine how we wouldn't have been there now.

In trying to figure out how to get there, I mean all the questions are really superb. Everything obviously, though, depends upon the nature of the data, in fact, that we have. And the data should be comparable across settings but they're not comparable across settings. So I do think we have to really work very consistently about how to get from here to there with sort of the basic information that

is needed, as opposed to all of the information that somebody thinks they might ever want.

DR. LOOP: I agree, and one goal would be to simplify some of these databases in addition to integrating it. I think for quality indicators we should try to stick with the objective indicators because many of the elements in the databases are very subjective. We should use the existing data, I believe you touched on this in your report, to have core quality indicators and then have additional site-specific indicators, no more than 10 or 12 core indicators like decubitus, new infections, drug errors, things like that. And then for each site have a specific set of no more than three, four, five for each site.

I think that those indicators, that's the way to do it, the objective being to instill feedback at the site so that they compare it with national benchmarks for each site. I think that that would do a lot to improve quality.

MS. RAPHAEL: I want to build on what Floyd said because I feel our overall objective should not just be to

measure quality but to improve quality. So that in five or 10 years, in some way, quality is better than it is today.

You mention in the paper, Beth, a demonstration of 50 agencies using OASIS against national benchmarks. My organization happened to have been one of those 50. There was an improvement in re-hospitalization rates.

It was very chilling for us to see how we stacked up on re-hospitalization against national standards, and it really was an impetus to try to improve rates of re-hospitalization. I think that's the direction in which we need to go.

And I agree with Floyd that we should choose five. Let's just start with five that we think are objective and important and try to measure those in a site-specific and across site way, and see what we find out and if we can create some national benchmarks. Because overall one of the things we need to do is send a signal. I believe that if you don't reward quality, then organizations are not going to invest in quality. And I'm not sure, through all of

this, how are we showing that there's any reward for quality.

There's two things. I call it the slap on the wrist and the pat on the back. You get a slap on the wrist if you don't make minimum standards. That's for sure. But where's the pat on the back or some recognition or some differential for, in fact, really improving your quality? And somehow I feel that needs to be thought through in all of this.

DR. BRAUN: I think I'd build on what Judy said. I thought maybe it was just because I was new to the commission, but as I was reading through the situation, I felt we're talking about steps but do we really have a clear picture of where we're trying to get in the end as to what a post-acute system should look like?

I guess one of the concerns I have is that sort of the patient needs to be the center of our thinking. Are they in the appropriate setting? Are they getting the quality of care that they're supposed to get? And I somehow

don't sense that in the way that the whole thing is put together.

DR. NEWHOUSE: I agree with the sentiment that we ought to be thinking about where we want to be in 10 years with this system and presumably it's with a more integrated payment system and quality assurance improvement system than we have now, which to me would imply common elements, to go to this first question here.

But I would remind people that getting there isn't going to be that easy because we have these separate payment systems that are calibrated on these elements. So it seems to me saying that likely implies some period of dual data collection, at least for some institutions to recalibrate whatever this new instrument is in whatever setting it hasn't been used in before. That is the weights, for example, on the HHRGs or FIM-FRGs would conceivably change with a different set of questions.

I think we have to go through that to get where we want to get, but I think that issue sits there.

I had a different issue that troubles me, although maybe people who are closer to the action could reassure me, that's not on the issues for discussion that I think should be, which is issues of auditing and upcoding. We know from the hospital experience that if you pay something for data you get different data than if you don't pay something for data.

In the hospital setting, we more or less took what was on the chart as the gold standard and we went back and audited against the chart. And more or less everybody seems fairly comfortable with that.

My concern is as you move out of the institution, this is obviously particularly for home health, how confident we can be that we have the analog of the hospital chart for accuracy of the data. Floyd mentioned subjective elements. I'm not sure what you meant --

DR. LOOP: Objective.

DR. NEWHOUSE: Are ADLs objective in your taxonomy?

DR. LOOP: Not really, but I did put them in as one of the core elements.

DR. NEWHOUSE: I didn't want to put you on the spot, but they seem so basic to the post-acute area that it's hard to imagine what either payment system or quality monitoring system we would have that we wouldn't have those data. But then the issue becomes both what the reliability, as we talked about in the context of some of our earlier discussions about big jumps in payment if you went from two ADLs to three ADLS, and how reliable was that kind of call.

But then there's the further issue that raises, it seems to me -- and I'd like to hear some discussion -- of how this is going to be audited. Because I've thought about it and seems to me that somebody has to almost come by contemporaneously and assess the same patient, to say this was or wasn't within some tolerable range of error. If you come by weeks later, I don't know what you audit or how you audit.

But the notion of coming by contemporaneously,

except for some spot-checks conceivably seemed almost out of the question to me. But maybe not.

I would be actually interested in how the managed care industry handles this in their business.

MS. ROSENBLATT: I don't have a specific answer to the question, Joe; maybe Janet does. But I did want to give my reaction to this chapter.

It seems to me that this commission, in looking at payment issues, has said things like we know there's no perfect answer but we know we need to do something. Like with risk adjustment. We know that using just hospital data isn't the perfect answer, but it's better than not doing risk adjustment at all. So let's go with that and make payment based on that.

I was looking in this chapter for something that said that. We know there's no perfect way to do quality measurement, we know there are lots of problems. But we've got to get started, and let's start with these steps.

And I really like what Floyd and Carol just said,

which is let's focus in on a couple of measurements. What I'd like to see in this chapter, and I hope there's time to do it, is maybe make a recommendation for four or five key measures that may not be perfect but at least give us a start.

MS. NEWPORT: I know a little enough about HEDIS to be dangerous, but I'll attempt to get to the question.

On the managed care side, I think that there is case study for developing what we're talking about and I think it goes right to what Carol and Floyd have mentioned, in terms of a simple dataset that is an indicator of a problem in a process. It doesn't mean it's the be all and end all in terms of trying to define at a very minute or micromanagement level that there is a particular claim that may have been inappropriately coded or inappropriately paid. But there are signals there.

And I think we need to look at that as a process, as an indicator, as a way to vet that the participants at whatever level, whether in the post-acute setting, whatever

defined services they're giving, are at least operating in an efficient and appropriate way.

So it's not a be all and end all, but it does give you a proxy at least for determining that. It may be across the breadth of the system. There are lots of ways to go and pierce into that once you have indications of problems.

So I think we have to look at it in terms of what its utility is, in terms of a minimum dataset, I think that's really appropriate. There's obviously some work done out there. I think the HEDIS process could be looked at as a way to start developing this. That was a longer term process in some ways, but it was auditable and there was a way, a protocol, for auditing that that all the participants in those particular settings could agree to.

So I think that it goes to starting somewhere and I think that it does speak to keeping it simple, even for the longer term, once you have a defined set of data that's useful. But I don't think it's necessarily totally reliable, in terms of exactly appropriate payment on an

individual basis or an individual setting way. I think we just need to use it as a way to assure people that we're paying appropriately for care.

DR. LAVE: I guess in terms of being helpful, and I like the way the direction is going. What I can't tell is whether or not -- what it would be interesting if you could do would be to give us your sense of the current instruments and what we can get out of the current instruments that are really related to the conversation, in fact, that we have here.

Floyd has said we should choose five things to look at and measure them, or whatever it is. Now do the current instruments that are being put on the long-term care plans, do they do that? I'm trying to get a sense for -- it seems to me that there are really two issues.

One issue has to do with that there are a set of instruments that have been imposed upon the system that they are required to fill in now, and that is going. Given those instruments, can we in fact, get any good quality

measurement from that? And how should that be pushed?

The second question, it strikes me, is sort of in a long-term where should we be going? And my sense is that we want to go for common measurements. I mean, I would like to know that if somebody is incontinent and is deficient in ADL one in a nursing home, that that same patient would be deficient in ADL one in a home health care or a rehab center, which I guess we can't do now.

So can you give us a sense for, in terms of outcomes such as Floyd was talking about, do the current instruments get us there at all? What don't the current instruments get at, in terms of that? With the exception of patient satisfaction, which you may want to come back to.

MS. DOCTEUR: I'm neither a clinician nor -- let me tell you what I think.

[Laughter.]

MS. DOCTEUR: Each of the different current instruments do provide a way of taking populations that have received care and saying have they improved, in terms of

their functional status over some course period of time. They all have different ways in which they do that. And they are designed to address some of the functional issues that are most closely aligned with the type of care that's provided by that institution.

And by that I mean there's a real question right now. Yes, you can use the MDS to say something about whether patient status has improved over time, but there's a question which HCFA is exploring right now about whether those are meaningful measures in terms of skilled nursing facility care. We know it makes sense or it's been determined by experts to make sense in terms of the long-term care side of things. And there's a question about whether it's also meaningful for skilled nursing facility care.

So all of the instruments, the OASIS, and the MDS, and the FIM can be used for that purpose. They're different, so we've got 24 long-term care measures that are designed to do that type of thing for the MDS. You've got a

set of measures that do that with the OASIS data. And there are measures that have been defined from the FIM, although Medicare isn't using those right now.

So yes, we could do the core measures right now and Medicare is starting to do that, in terms of looking at functional outcome improvement. What it doesn't do is things like looking at processes of care, determining whether there is underuse of care, looking at the services that are actually provided and looking at the quality of those. It really focuses on improvements in functional status.

DR. KEMPER: I wholeheartedly agree with trying to go toward a common system, though I think it is the case that the patient mixes are very different across these settings. And so you can't have a common instrument that works for everyone. Or put differently, there will have to be large blocks that don't apply in one, mostly don't apply in one setting because those kinds of patients don't go there. And one question is how useful is computer

technology in actually doing some of these forms and could HCFA be helpful in that?

I think while that long-run objective I share strongly, I think it's important to recognize and give HCFA credit for having developed these quality monitoring systems for the individual sectors and they're responding to a lot of different objectives. I mean, it's a little bit like the underdeveloped countries where one got the trains from the west and another got them from China, and the World Bank comes in and says you really need to maintain your capital stock, and goes to the other country and says you really need to maintain your trains and keep them running. And then on the third visit comes in and says but the tracks at the border are different gauges and you can't run the trains in the other country.

I mean, that's sort of what's happening with these assessment tools in these quality monitoring systems.

The FIM-FRGs, the question of whether to use the MDS-PAC or the FIM-FRGs in the rehab hospitals is a really

good example for that. We've recommended use the FIM-FRGs knowing full well that the SNF payment uses a very different methodology. And you can't, in the short run, bring those two together. In the short run, the FIM-FRGs is the only thing to use because that's what the payment methodology was developed on.

So I think to be helpful, we need to think about that long-term, where one ought to be, as Bea suggested earlier, but not derail all the good work that's been done in the meantime. I mean, HCFA has taken a start on quality in the SNF and the rehab hospital and the home health area. I think my own view is that we ought to strongly encourage HCFA to have a similar effort on the home health side of monitoring quality as on the SNF side, and that ought to become a major objective. But use these tools that are out there and not derail them at this point, but try to be helpful in how to get to a long-run common system.

DR. ROWE: I'm at risk because I'm not a health policy analyst, but I am a clinician, our used to be. I am

a little concerned in our conversation that we're mixing up a number of things, and I think it would be helpful to have a clear description of the issues in the beginning of the chapter. It may be there, but I think it could be clearer.

I think that we have to dissociate the location of the care from the kind of care. The discussion here assumes that if you're in a nursing home you're getting long-term care and if you're in a hospital you're getting acute care. The title of this is supposed to be post-acute care but I think some of us are confusing post-acute care with long-term care, which it certainly isn't.

I could walk down the ward of a hospital here in Washington with you and I could show you patients who are getting long-term care. They happen to be getting it in a hospital. Most of those patients would be dying. They would be at the end of life. They would have cancer and they would have gotten dehydrated at home or an intestinal blockage or pain uncontrollable with medications at home, or something, so they get admitted to the hospital. Or they

may even have an intercurrent illness that's complicated the end of life, like a pneumonia or a decubitus ulcer, or something. Many of the patients would be demented and they would be in a phase of gradual loss of function.

Then there are patients who actually get discharged from the hospital for post-acute care. That's rehab largely, or recovery from a pneumonia or something else. Some of those patients go to nursing homes, some of them go to home care. And then there are patients in nursing homes who are entirely different and they're getting long-term care. They're not getting post-acute -- there's nothing post-acute about the care.

Each of these patient populations deserves a different kind of measurement. It is not fair to say that -- and this is where I start to get concerned -- is that we throw the word quality in as if if your functional does not improve you're getting bad quality care. Well, if you're dying your functional status is not going to improve and it doesn't mean you're getting bad quality care. So we can't

use those kinds of outcomes.

So I think we have to have some kind of an intellectual grid that tells us that the patient is at the center of what we're concerned about, not the locus of care. And that we should recognize that there are different kinds of patients on different trajectories with different needs in different locations. I think that that would help us from overlapping quality with post-acute, with long-term, with SNF, with hospital, et cetera. I hope that's helpful.

MS. DOCTEUR: I think both of those points are excellent and I'd like to make two comments in response. You're right, the paper doesn't deal with that issue, the difference between the care and the setting. But I made this table to try to kind of illuminate some of that.

DR. ROWE: Actually, it's what led me to make my comment, so I think if you could extract those critical concepts from this and put it in the beginning of the chapter, it might be a guidepost for people if they're reading it.

Otherwise, if you're not a clinical and all you are is a sophisticated health policy analyst you might -- not that our system doesn't mean that you should rule Medicare, because that appears to be the way it's done, but you might slip from one category to another.

MS. DOCTEUR: I think that definitely the next iteration of this will make that point better.

One issue that I think is worth illuminating also in the same vein, is that we're building these quality monitoring systems on payment tools. And when the payment tool is driven by the setting, you get into a weird situation. We could say if it's a rehab patient in a SNF then we use the FIM and we collect the FIM information. Then you start getting into burden issues. I think this is really a key issue that needs further development.

I wanted to also respond to your second point, though, because I thought that was a useful one, also. That was concerns about there are certain patients that you don't expect to have functional improvement. And I want to be

fair to the measurement tools that do exist on both OASIS and the long-term care measures that have been developed.

DR. ROWE: They have a prognostic factor in them.

MS. DOCTEUR: They do, yes. They to classify patients by certain characteristics that are designed to adjust to that.

DR. ROWE: I think that is true, and some of them do do that and you start with and say what's a reasonable expectation for an outcome here and then you measure against that. But our discussion here did not sound that way, and it was kind of mixing quality with change in functional status. And I want my colleagues to understand that we can't always do that.

DR. WILENSKY: Let me go back though to raise a point and to try to see whether we might be able to give some guidance in the next iteration. Floyd has raised it, Jack has touched on it, and a number of other people. You've included in the paper but it's sort of like how do we make the next step.

One of our problems is that we have disparate payment systems. There is information that is needed in order to continue the payment systems. And then there are functional assessment and outcome or other quality measures that we want to do.

I don't know whether you, either individually or maybe working with some of the payment people, would be able to give some guidance about how much we might pare down of existing data that is being collected in these disparate areas so that we could then plan to construct measures of quality that focused on the patient and the patient's condition, irrespective of the place that they were being treated, that would be really focusing on function and quality and not being used for payment.

The reason I've stressed this linkage is I have a lot of sympathy when I look at the various forms that nursing homes or home care agencies are supposed to be filling out. My bias has been that these are sometimes researchers gone wild who are not trying to be bad people

but aren't in the position of having to actually provide care, particularly on limited budgets. And that there hasn't been this pressure of saying all right, what are really the minimum information that we need in order to pay?

And then to try to think about if we were to develop common core, as Floyd has done, common core and specific elements that we would then use so that, at the very least we do not exceed what we're doing now in toto, and hopefully reduce the burdens by 10 or 15 percent in toto, but really realize that we need to have both functions addressed.

We need to be able to pay properly. That means being able to have a classification system that's driven by clinical characteristics of the patient and other issues. But we also need to know what's happening, in terms of quality and outcomes. We've got to be reasonable in terms of what is being pressed on there.

I think that there is a tendency, when people are putting together monitoring instruments and payment

instruments, that there really isn't adequate attention as to the burden and the cost. And I don't think that there is a focus on the fact that you might be dismissive of the complaints of the industry as the person putting together these instruments -- which is sort of one position -- without really paying attention to the fact that this just means you're going to be taking off money that otherwise would go to care.

And if we could get that point embedded in our thinking a little more, that if we get too carried away with the kind of data that we're collecting, that we really are going to be doing a disservice to the patients who are just likely to have some of what could otherwise be available for treatment used and having people filling out multiple forms and probably not filling them out that well.

But there's no way to give us advice or have us suggest about how to go forward without really treating these as a whole. Because we can't just cavalierly say dump it and we'll let the payers worry about how they're going to

pay.

DR. NEWHOUSE: It seems to me there's a corollary though that these common data elements then will also drive the payment system or what payment systems are feasible to construct. Because of the data element isn't there to pay on, it isn't there.

DR. WILENSKY: But I think you have to be -- I think we're entitled to have some elements that are there for one function and some elements that are there primarily for another function. If the information isn't going to be in the system, you can't use it for payments. That's clear. But I think that we need to understand that we really will have some variables. We don't need to have only the same variables used for entirely both purposes.

DR. NEWHOUSE: I fully agree with that, it's just that when we're talking about the common or the standardized data collection system it has to fill both functions.

DR. WILENSKY: Yes, and I think that if we're going to -- on the grounds that this is not immediately

about to be adopted into law, taking --

DR. NEWHOUSE: Or regulation.

DR. ROWE: As opposed to everything else we do.

[Laughter.]

DR. WILENSKY: But this is an issue, when you see the forms as Floyd held up this OASIS form or other forms that so-called minimum dataset, that it's hard -- even for people who have no responsibility in ever filling these out, it's hard not to feel pained by what is being asked for. And I think it really makes it important that we understand and balance, and now we're really going two functions.

We want to have a reasonable set of information that will allow us to differentiate our payment, and we would like to have a way to measure quality and outcomes, and there's only so much time and questioning that we can do.

DR. ROWE: I'd like to extend my recommendation just a little bit further, if possible. I know this would be a highly atypical approach for us, and it may not be

appropriate, but maybe what you could do, Beth, is in the beginning of the chapter, when you address these issues -- and I agree with Gail about the burden of reporting, particularly when it's not relevant to the particular -- you've got the wrong form for the particular patient because the form is dictated by the building you're in as opposed to the patient you're treating.

Would it be helpful to the people who are trying to understand what we're doing to have a little vignette of two or three different kinds of patients? Describe a patient, an 82-year-old woman who lives alone and who has a hip fracture and is transferred from an acute care facility to a rehab or a SNF, is covered by Medicare. And another patient who is at the end of life. You know, a patient in home care. Susanne is a physician, she's on the staff, or I or Carol could -- here's Carol, so I'll give her an assignment. Carol can help you.

Maybe two or three different things that would just, very quickly, in three or four sentences each, capture

a Medicare beneficiary. That would be a novel thing for us to do, actually. And then people would understand who the people are that we're talking about and how they are not all one gamish of homogeneity. I'd like to at least try that, maybe in the appendix, if not in here.

DR. WAKEFIELD: Just to comment on the chapter. I just found it incredibly interesting that there were so many different data sources across these various settings and clearly there's a terrific challenge in trying to seek out those common threads that could be run through all of those different settings.

I would have pitched the same question, is there any uniformity at all in current data that are be collected? So if we saw a Venn diagram, for example, what would come out right in the center of a Venn diagram that had those different data collection measures? But basically those issues, I think, have already been raised.

I just want to ask for clarification on a comment. In response to Floyd's recommendation, which I think is a

good one, that is some core indicators and some site-specific add-ons, are we now suggesting that at least at the start we'd be asking for that kind of information to inform not just quality assurance and quality improvement, but also payment? Is that what we're asking for here? That that information would be used for all three of those purposes at the start?

DR. LOOP: I have a problem mixing quality indicators with reimbursement, and if we're going to talk about quality, we ought to talk about quality. A lot of the policies, and I realize your ultimate chapter can't be an editorial, but policies have asked for more and more quality through greater documentation at lower cost. That just doesn't compute. We're not going to be able to do that.

That's why I started out by saying that we have to simplify these databases. Some of these take up to two hours to fill out, as Carol more than anyone knows. I think it's possible to integrate them. I don't think we need all those different forms. If they're driven by reimbursement,

we ought to be able to separate that out.

DR. WILENSKY: The only problem is, I don't think that we are talking about reimbursement here. But to the extent that what we use to reimburse requires information, then we need to lay out the entire picture of information that we will ask facilities to provide. Because otherwise we're just going to fall back into the same trap, which is this is what we need for quality but we're going to be knocking on your door next week and hit you again for what we need for reimbursement.

So what we need to do is to have the instruments that we are satisfied with that we can use when we're doing reimbursement. We want to have the instruments that we want to have for quality. We want to try to make sure we are including the data elements that will provide information on both, but that we're not getting carried away because the fact is that that total amount of data collection is what drives the burden.

I think it's not we're using literally the same

questions to drive both of them, but that we want to get it at the same time.

DR. LAVE: This is sort of a statement and that is that, at the current moment, as I understand this, the MDS is in place and it is used to drive reimbursement, both at a number of state levels and for the Medicare payment system. The OASIS is about to start driving payment for home health. The MDS-PAC and FIM-FRG maybe is about to start driving.

We are now talking about a world whereby we have a set of instruments in place. And it strikes me that our responsibility at this point is two-fold, one of which is to sort of say what can we do with the instruments that are in place to inform quality? Can they be used to inform quality?

The second thing is to say given that these instruments are being devised for multitudinal purposes, can we be more creative in thinking about the nature of instrumentation down the future so that the instruments are less burdensome as used for the current function but we can

do a better job.

For instance, one of the things that struck me as I was reading this was that one of the important things in all of these settings is whether or not a person is functional in the ADLs and IADLs. Now one would think that each one of these instruments would ask for ADLs and IADLs exactly the same way so that the patient would be deficient in ADL number three in each of these settings.

But for some reason or other, each one of these tools has taken a different way of measuring these things. So it strikes me that there is both a long-term agenda for which, in fact, I think the goals that Floyd and Gail had expressed ought to be the driving characteristics. That is, if you're measuring a domain, that that domain should be measured the same no matter what setting you are in.

And if it turns out there are seven different ways of measuring this domain, you get the providers or somebody to sit down and bash it out and say which is really the better way. That has to be an answerable question. Then we

want to know what are the domains that we really need to measure, so that you cut down. And how are you going to use that information.

So the short term, as I understand it, is what can we do with the instruments that they are currently required to do, on which we are currently basing payments? And then what is an efficient strategy for moving to a better system that allows us to classify patients across settings, to answer Jack's question, like we have patients who are dying in nursing homes. We have patients who are dying at home. So you would want to know the same things about them.

So that's the short term and the long term.

And then, as I understood the other short-term question was is there, in the short-term, something else that we should be asking with respect to quality that isn't on the radar screen? And the something else that I understood was whether or not, in fact, Medicare ought to have a patient satisfaction component with the quality of care as seen through the eyes of the people who are

receiving the care and their caretakers? Is that something that, in fact, we would believe to be important because we are giving these services to old people and I would like it that my mother is happy where she is, and she feels she's being taken care of well.

And so my sense is that if I had additional money to spend, I would like to know something about how the beneficiaries who are receiving these services actually feel about them, because in long-term care, I think more even than short-term care, how the utility that the patient gets from the environment and the setting is even perhaps more important than it is in the acute care setting, where you're going to be there for a very short period of time.

DR. NEWHOUSE: In the interest of thinking where we want to get to and stripping down data, I have another suggestion. This discussion has been framed in the context, although it was never really put that way, that we were collecting these data on everybody that Medicare was treating. Indeed, I think we have to collect the payment

data on everybody to pay them.

It's not so obvious we have to collect quality data on everybody. I think there may be a core set of quality indicators that we collect on everybody. Then we may want to do some kind of sample of patients, to stay with Jack's patient-centeredness, and go to the records for those patients and collect data elements. I mean, I don't know what would be in the 100 percent sample if we did this and what would be in the smaller sample.

But it seems to me that option certainly is out there, and I think is probably desirable.

DR. KEMPER: I agree with all the long term recommendations and direction. I think that's important to be in the chapter. I also think it's important to focus on the short run and in the home health area, in addition to urging HCFA to have a similar effort to monitor the quality effects of the new prospective payment system, I think it would be useful to talk a little bit more about monitoring medically necessary care and how that would be done and how

that might be refocused on under use rather than overuse, given the nature of the change in payment.

On the SNF side, I think it's important to track changes in quality. I mean, there is a system in place to use these measures to track quality. To track those changes and report.

You mentioned the possibility of using the demonstration data to look at the effect of prospective payment on utilization and so on. It seemed to me that that was something, it's not the nation, but it would be very useful to use those data to try to track changes for SNFs. I don't know if there are practical problems in doing that, but I would urge us to make a recommendation along those lines, so that we see what the SNF payment is doing.

And then, in the rehab hospitals, it seems to me the FIM-FRGs, and I think you mentioned this, should be possible to be used for some kinds of quality indicators. Again there we're making a payment change and I think HCFA needs to put in place some monitoring effort there.

So while we're getting to this long run better world, I think we really ought to push monitoring the effects of these payment policy changes.

MR. SHEA: I don't disagree with the point about trying to simplify, and I positively agree with the standardization drive. I actually think we need to make sure, in at least our thinking, we extend that to include not just HCFA but all the agencies, whether it's the accreditation bodies, because they have a whole set of things that they're doing and future things that they plan to do which are going to be additional burdens.

But I just would caution that even though it's been helter skelter, the development of attempts to measure quality in some of these settings have been in response to some pretty difficult situations and experiences that consumers have had. And I just think this obviously is the common and difficult question of striking a balance.

But I just wanted to put in a word for being careful as we do this to make sure that we're getting

towards better measures of quality, not just less collection data, because I don't think that's, in the long term, going to be to anybody's real benefit. Even though we should try to simplify this as best we can.

DR. WILENSKY: Any other comments? Beth, I hope we've provided you with guidance, or we at least have provided you with lots of different ideas.

Sally?

DR. KAPLAN: The purpose of this session is to move forward with your comment letter on the home health prospective payment system. But first, I'd like to give you some information about the Balanced Budget Refinement Act, or BBRA, provisions on home health and to answer questions you posed at the last meeting.

The BBRA changes, first of all, the 15 percent reduction will go into effect one year after PPS implementation. In other words 10/1/01. The Secretary, in the meantime, is required to report on the need for 15 percent or another reduction. The Secretary's report is due

from six months from enactment, or in May 2000.

DME is excluded from the PPS consolidated billing, which it was as you might remember from your mailing materials for the last meeting, it was included.

During fiscal year 2000 home health agencies will be paid $10 per home health user to collect OASIS. This is for each user. At least half of the estimated amount is to be paid to the home health agencies on 4/1/00.

There is an increase in the per beneficiary limits of 2 percent in fiscal year 2000 for home health agencies that have limits below the national average. Home health agencies will be required to maintain a surety bond for four years, and the bond must be either the lesser of $50,000 or 10 percent of their Medicare payments for the previous year.

Not on the slide is a requirement for MedPAC to study the feasibility and advisability of exempting from the PPS rural home health agencies or services to individuals in rural areas. We will be discussing shortly how we're going to accomplish that.

I also wanted to answer questions that you raised about the PPS at the last meeting. First, is there a transfer rule? The answer is if the patient is admitted to the hospital and returns to the same home health agency without a significant change in condition, he continues in the same episode. The rule does not specify hospital type.

Another question was whether HCFA was going to provide beneficiary education. This issue is not addressed in the rule and we've added a paragraph on this issue to the comment letter, but it was not in your mailing materials. We're discuss this later in the session.

Are outliers included in the HHRG groups for the case-mix? The answer is yes, with the exception of episodes with one to four visits, which were excluded from the case-mix groups.

Finally, does the statute allow a transition? The answer is yes, BBA allows for a maximum four year transition to PPS, using the interim payment system as the non-episode part.

In the previous meeting the Commission raised various issues about the proposed home health PPS. Staff has come up with four broad options for proceeding with the comment letter. I'd like to begin with these options.

First, would be to support the PPS, expressing your concerns and also the need for refinement over time. The second option would be to suggest a blend of per-visit payments with episode payment until the Secretary could evaluate the episode payment.

The third would be to suggest a shorter episode, 30-day episode. And the fourth would be to suggest that the PPS be substantially revised.

I think that what the staff decided was that we really need to come to some kind of consensus, or give us some direction on which of these four options you would like to proceed with before we get into the other details that the comment letter would address, because the other details of course are going to depend on what your decision is, that this is really the overriding decision that we need to

reach.

DR. WILENSKY: Let me open it up for your comments here. Again, in making your comments, I don't think there's any question that a number of concerns have been raised. I think we really want to address the bottom line, which is having appropriately expressed both areas of concern and presumably giving specific instructions about where we would like work to go on or the kinds of changes that we would like to see implemented over time or whatever, as a bottom line point.

Are we saying yes, we think we should go ahead, sometimes for some people maybe holding their nose, as we have done with regard to the risk adjustment issue? Or is it so problematic that we would say grind it to a halt and stay with where we are now, which is the interim payment system?

MR. MacBAIN: Since this is a comment letter addressed to the Secretary rather than talking about a normal report, it seems to me ought to do focus on things

that the Secretary could do within current statutory language. So given these four options, I assume number four is something that would take a change in the Act, and we may not want to deal with that in the context of a comment letter but somewhere else.

Are the other three options all possibilities within the context of the Act? Particularly number two is the one I'm concerned about, whether the blend...

DR. KAPLAN: A blend of the IPS and the PPS would be possible under current statute, I believe.

DR. NEWHOUSE: I guess the question is whether a blend could be characterized as a prospective system under the current statute.

DR. KAPLAN: That is a question, I agree. But it does allow for a transition, so that if you transitioned using a blend, you could do that. I'm not pushing that by the way, I'm just answering your question.

DR. WILENSKY: Are there any other comments? We've discussed this issue a number of times. Is it a

consensus of the group that whatever our concerns, that we would prefer going ahead with the prospective payment to be modified in ways that we can start discussing, as opposed to suggesting that we stay with the interim payment system because the prospective payment is sufficiently bad?

DR. BRAUN: Gail, I'm still not clear on whether two is actually an option, because one and two could both be together. But is two really an option? I mean, I guess you could consider it a transition, but it is and it isn't.

DR. KAPLAN: You would have to consider it as a transition to the PPS.

DR. BRAUN: And therefore, it would not be an option.

DR. KEMPER: I thought you said you can't have a transition with anything other than the IPS.

DR. KAPLAN: That's correct.

DR. KEMPER: And that's not what option two is.

DR. BRAUN: That's not the option that's here.

DR. KAPLAN: Yes, that's true.

DR. WILENSKY: I guess, to the extent that we wish to recommend, if it can be legislated in a timely way, that rather than have the blend with the IPS and the prospective payment, that we do a blend with something else and the prospective payment. We can make that recommendation to the extent that either HCFA could do it in time, and/or the legislation supporting it would occur. And alternatively, one of the questions is do we want to use the IPS prospective payment as a blend?

VOICES: No.

DR. WILENSKY: I think that if we're going to be practical in our advice, we need to do both. If the other could occur in a timely way, both legislatively and in terms of implementation, this would be an improvement. Otherwise, there's no reason not to recommend it but start with the PPS and then move -- I mean, in the same way that we traditionally start with a blend and then either move to full prospective payment or stay with the blend, there's no reason you can't start with the full prospective payment and

move to the appropriate blend in two years.

DR. NEWHOUSE: I think realistically the only thing we could start with, if we want to start, is the prospective payment system. But the distinction here, I think, is whether number two would require new statutory legislation or merely advice to HCFA to work on a blended system that would be a prospective system.

DR. WILENSKY: My guess is it would, but there's no problem, to my mind, in making a recommendation, acknowledging it would require legislation, as long as you're giving direction about what you want to happen in the fall, which is that you proceed with full prospective payment not needing statutory authority. Here's what we think you need to do in the future, recognizing it will require statutory authority.

DR. BRAUN: But it seems to me that we need a definition of prospective payment because it's different in different settings. I mean, a prospective payment in SNF is per diem. Prospective payment in the hospital is DRG, which

is a lump sum.

DR. WILENSKY: They have it in the rule. I'm assuming when we say go forward -- and maybe this is incorrect -- we are saying go forward with the 60-day episode, as it's defined in your rule.

DR. BRAUN: But that's a rule, a reg -- a proposed rule, but it's not a legislation --

DR. WILENSKY: I understand that. But I am assuming that what we are saying that because the interim system is so bad, that we want to go a prospective payment system, and that the practical effects -- although maybe this is untrue, but the practical effects of a major redesign would mean staying with the interim system longer while they redesign the rule, that we are saying go forward on your scheduled basis with what you have, in terms of its major dimensions. Here's what we're telling you or recommending be done after October 1st, to improve it.

And if I'm hearing what people are saying, among other things, we can decide whether we like 60 days or we

want to change 60 day. We can also recommend, if we agree as a group, that rather than have only prospective payment, we do a blend between a per-visit payment and prospective payment, understanding that will not be October 1st, 2000 but it will be as soon as HCFA could get the work done and the legislation passed that would support that.

DR. NEWHOUSE: Except if I understand it right, they may not need legislation.

DR. WILENSKY: That is not -- all we need to do is, if we think it may need legislation, then we ought to indicate it may need legislation. If we can get a ruling from HCFA or from our own legal staff that we don't think it does, in general I think we're better off to recognize if a recommendation we are making requires legislation to state it, so that we distinguish between those things that we can't do without legislation. Obviously, we are not the ultimate authority on that.

DR. LAVE: Without having actually seeing what happens when you implement a episode payment, it's hard to

know what will happen, but my sense is, given how strongly the home health agencies responded to the incentive to increase visits under a visit-based system, my expectation would be there would be a strong incentive to cut visits and services under a fixed episode based payment.

So that my preference would be to suggest a blend of a per-visit payment, so that there is some marginal payment associated with additional visits to people. I don't know what the right blend is, whether 50/50 is the right blend, it certainly should be nationally weighted and wage adjusted.

But I don't quite understand what we would gain by doing 30. Given how strong the response has been to the incentives under the prior system, I would feel more comfortable with the per-visit blend.

DR. WILENSKY: Let me just stop here to try to get a sense -- I think one of the reasons we raised 30 is without the blend, the longer the episode, the more stinting seemed to be a serious issue. If we're talking about a

blend which mixes the incentives, then it may become less of an issue if you have a reasonable classification system which gets the payment right and you've done something to try to get the incentives to be less of a problem.

So is there any disagreement that it would be better to go to the blend than to stay with pure PPS? Is everyone comfortable with the notion that we recommend that we go to a per-visit blend with PPS when feasible and with legislation, if it's needed? Or are there some people who are concerned about the mixed incentives that a blend would suggest without, at this point, saying whether we mean 20/80, 50/50, or 80/20 because I don't know that we have talked about that at this level?

DR. LONG: Just a terminology question here. Both per-visit and per-episode can be prospective? So we're not mixing per-visit in a cost-based sense with prospective on an episode? We're talking about prospectively setting per-visits and prospectively setting per-episodes and blending those?

DR. WILENSKY: Yes, right.

DR. ROWE: Just to clarify, I should remember this, but these elements that are being blended, are these locally wage adjusted or are these national averages?

DR. WILENSKY: No, they're locally wage adjusted.

DR. NEWHOUSE: We can say whatever we want. This is not HCFA's proposal. This is what we're talking about, but we're talking about them in the context of wage adjusted, yes.

DR. ROWE: I just wanted to make sure that that point doesn't get overlooked because sometimes it has in the past.

DR. WILENSKY: And sometimes that's been an issue with some members.

MS. RAPHAEL: In terms of moving toward a blend, my main concern is that in no way could that work to delay moving from IPS to PPS. That's just sort of the bedrock for me.

Secondarily, I do believe that it has to, from my

point of view, it's important that we address the inequities in great variation that exist currently, and this has to be a national sort of payment for the prospective visit payment part of this.

Thirdly, what effect could this have on aggregate expenditures if you have a blend of this sort?

DR. WILENSKY: It could increase them -- could decrease.

MS. RAPHAEL: I guess prospective payment could if you have a lot in the higher ends. So either one of them could, the blend or --

DR. NEWHOUSE: I think we should talk in this discussion as though this is budget neutral. First of all, we don't know. And second of all, one can always set the amount of money.

DR. WILENSKY: But again, the intent of the recommendation is for HCFA to proceed now as it has proposed so yes, it will be the move from IPS to prospective payment. But to start immediately on the refinement which, from our

view, would mean doing a blend of a prospectively set per-visit amount and a prospectively set per-episode amount, national measure but with local wage adjustments.

Now we can't guarantee that's what would happen, but that's what our recommendation would be. And to the extent new legislation is needed, that we recognize that will also have to occur. And again, I don't know whether it is or not.

DR. KAPLAN: Then I think we ought to proceed -- I'm sorry.

MS. ROSENBLATT: I was just going to raise the issue that I agree philosophically with the blend. Once again, I'll be the voice of conscience as far as operational details. I just don't know if there is any problem in actually carrying it out, aside from the legislation.

DR. WILENSKY: Rest assured that this would require regulatory change and you will have a chance to hear from the industry about whether they think it has an operational implication. Again, I think the real concern

has been the stinting incentive.

DR. WAKEFIELD: I'm fine with that, Gail. I just want to keep my place, in terms of specific comments about aspects of this letter. So before we leave this topic entirely, I don't have a comment on this.

DR. WILENSKY: That's fine. We're going to get -- I know Joe has reminded me that we haven't talked about the spike problem after four.

DR. NEWHOUSE: There's incentive problems at both ends. There's the stinting at the high end and the spike at the low end.

DR. WAKEFIELD: The specifics of the letter now; is that okay? Just a couple of comments.

First of all, I just want to say I appreciate the inclusion of updating the wage index, both points that are raised. That is, concern about using a hospital wage index for home health. So I'm pleased to see that there and hopefully that would be perceived as being very strong, in terms of how its worded, a strong concern.

Secondly, I'm also pleased to see the comment about the hospital wage index, failure to control for occupational mix. I know this is sort of a recurring theme, but I really think that needed to be stated, and I was happy to see that, as well.

The one question I've got relates to the last section and that is under monitoring home health agency reporting and services furnished. Here's my question, I'm concerned about whether or not, as we list our concerns in this section, I'd personally like to ask HCFA to monitor in some fashion the impact of this new payment system on low volume home health agencies that are the sole provider in very sparsely populated areas. And I have that concern stemming from whether or not seniors will be able to continue to get the services that they need given these payment changes.

That's what I'd be requesting, whether or not we could ask for that kind of monitoring, a particularly sensitivity to it. Again, my consideration then would be

based on what they find, whether or not at some point in time there should be the development of some special payment system to control for that. That would be sort of a step two. But at the very least, to ask for some attention to be paid to those potentially fragile and only providers that seniors can access.

DR. NEWHOUSE: It's really the analog of sole community hospital, sole community home health agency.

DR. WAKEFIELD: Exactly. I'd be asking for exactly the same thing.

DR. NEWHOUSE: I think I was just going to make the point that I made. I have some specific comments as we go forward with what Sally has.

DR. WILENSKY: This is now the time, I think. Why don't we go through the specifics. There is, when you think about the section on incentives, to remember our concern is with incentives in both directions, at both ends. So it is both the stinting within the episode and the spike. I don't know if you have specific recommendations that you'd like to

see about how to resolve that, not again for October, but for the future, with regard to --

DR. NEWHOUSE: A blend addresses or blunts both, or helps to blunt both of those, depending on where you set the blend. The only other implication, it seems to me, is to gear the monitoring system with the knowledge that those are the incentives. As Peter said before, one would like to have measures of underuse to...

I think the other issue that I have, in terms of the spike, is HCFA says in its proposed rule that it's going to monitor agencies that have five and six visits, which is understandable. But then my question is what are they going to do? I mean, is somebody going to say that the fifth visit wasn't a necessary visit? And if so, what are the criteria for saying that?

DR. WILENSKY: I assume that they are going to monitor in the same way that Mary wants to monitor what happens to sole community nursing homes. Once they've monitored, they can tell whether they have a problem.

DR. NEWHOUSE: If you see a big blip in the number of five visit episodes, you can infer that there is a response, but then the question is and then what?

DR. LAVE: I guess the concern I have about the five visits is it really depends on the case-mix stuff, because there could be -- if I think about the post-hospital case-mix visits, some of them are really quite small. So you might expect to see a number of six and seven visits there.

But the incremental payment to the hospital at the case-mix classification system shouldn't be too high because one would imagine that the overall payment would be close to the four visits. So to some extent, you would expect -- I mean, the problem is it would depend upon the case-mix where it observed, where you observed the spike.

DR. NEWHOUSE: Aren't the lump sum payments over and above what you got for the first four visits?

DR. LAVE: No. I would assume that you don't get any payment for the first four visits. If it's the fifth

visit, my assumption would be you would get the episode.

DR. WILENSKY: No.

DR. LAVE: So that blunts the incentive for short stay visits, for short stay episodes. For high cost episodes --

DR. WILENSKY: Is that correct?

DR. KAPLAN: Basically for what we're calling the low utilization episodes, they're getting a standard cost per visit by discipline. And when they go to the fifth visit, then they get the episode payment.

DR. LAVE: And they don't get any before.

DR. KAPLAN: They do get per visit, yes.

DR. LAVE: So they get paid for four visits and then an episode for the whole fifth?

DR. KAPLAN: No, no.

DR. WILENSKY: If you have six visits you only get the episode.

DR. KAPLAN: Yes, and if you have less than five visits, you get per visit.

May I also interject here that HCFA is responding to some of the things that you expressed interest in last meeting. One of the things they're doing is they are looking at low utilization episodes vary among the HHRG groups. There was a lot expressed about if you had someone who was extremely ill that they might only have four visits, they wouldn't continue with an episode, but that there would be high cost for those four visits. And they're also looking at that right at the moment.

As far as the low utilization episodes also, another alternative that the staff thought about was something that we could suggest other than monitoring with vigorous enforcement, with extremely vigorous enforcement, although it would take into account your comment about how are you going to determine that it's not appropriate or is appropriate, is for HCFA to possibly move to a policy similar to payments for short stay PPS hospital patients.

MS. RAPHAEL: Sally, I just want to be sure I fully understand this. Could you explain to me how a blend

would work? Take any HHRG and just kind of walk through for me how it would actually be working?

DR. KAPLAN: How it would actually work. I don't think we can say for sure because I think HCFA would be taking into account different perhaps behaviors as to how they would do it. In effect, if you had 50 percent episode payment and 50 percent prospective per visit payment, and it would be based say on a standard. For instance, what they're basing the LUPA on, or the low utilization payment adjustment, on where it is based on say BLS payments per discipline.

Then they would estimate that there were so many visits in a particular type of case-mix and then I'm assuming they would pay a certain amount of that in advance.

DR. NEWHOUSE: You could even start this at the fifth visit, in principle. You could do exactly what you're doing for the first four visits now.

DR. WILENSKY: And then go to the blend.

DR. NEWHOUSE: And then go to the blend starting

with the fifth visit.

DR. WILENSKY: So it's just a weighting -- I mean, what you're doing is rather than doing a full episode, that you temper it by the actual per visit payment.

DR. ROWE: So you would pay according to the current --

DR. WILENSKY: Not the IPS.

DR. NEWHOUSE: That's not what I meant.

DR. WILENSKY: It's according to the measure they're going to be using for the first four visits. If there are no more than four visits, HCFA is proposing that it be paid on a per visit basis, 100 percent. They have a set of rules about how to figure it out.

DR. ROWE: Right, I understand that.

DR. WILENSKY: What a blend would say is that after the fourth visit, when you talk about the world of the episode, that you weight the factors between what you would get on the episode versus the per visit.

DR. ROWE: Okay, I understand.

DR. WILENSKY: It's partial capitation in this world.

DR. ROWE: Are you accepting Sally's example of a 50/50, because she --

DR. KAPLAN: I was just using that as an example.

DR. WILENSKY: No.

DR. ROWE: I wanted to clarify that because you wanted to know how it would work and she said 50/50, whereas before we heard we didn't know.

DR. WILENSKY: The point of how it would work would be whatever it is, this is an example, you have to pick one. We are not making a recommendation because we don't have anything, I think, at this point to bring to the table. We haven't thought about it.

DR. KAPLAN: You're asking for a blend but you're not specifying a particular percentage that the blend be composed of.

DR. KEMPER: I just wanted to ask a question about the recommendation up here. I strongly support this. I'm

more focused on after a year or two of experience than I am right now. It might be nice to do now.

My question is are the data available to do the refinement, because my impression was that the data on resource utilization collected for development of this is different from the data that will be collected in an ongoing way. So I think the ability to refine is extremely important, but can you comment on what data you would need to do it?

DR. KAPLAN: I think to refine it, you're not going to be able to get exactly what you had in the case-mix research. I think that you can use the combination of the OASIS data and the data that is called generically the 15-minute rule data. Whereas home health agencies are now required to report on the claim, in increments of 15 minutes how much time was actually spent on the visit. And since that's already ongoing, they've been collecting that data and reporting that data since August, they might not have that immediately. They're also not sure how accurate that

data is because it's brand new data that's never been collected before, but at least would give you some idea of resource utilization.

DR. KEMPER: Is it by discipline?

DR. KAPLAN: Yes, it is by discipline? It's by visit.

DR. KEMPER: And what about the cost data necessary to revise?

DR. KAPLAN: Well, they'll still have the cost reports. But I believe what they did in the case-mix research, they did not use individual home health agencies cost to come up with the weights for each HHRG group. They actually used a standardized amount by discipline to come up with the weights, per minute.

DR. NEWHOUSE: I was going to wait to make this comment under the later one, under auditing, but it comes up here, too. I don't know how much we know about -- well, you can tell me because I don't know much, about the accuracy of the OASIS data. Has any -- I mean, we know for example when

we set a separate DRG for tracheostomy with a big weight, that we had 10 times as many tracheostomies reported in the data.

My concern is that -- there's no problem with trying to refine the case-mix, but are we really confident that we're going to get closer to the truth? That is to say, are we really confident that the OASIS data that are going to be used for this refinement represent reality?

DR. KAPLAN: I think it's the same issue that you brought up, that how are we going to -- you know, that there is this issue of how accurate the data is. I think it's the same issue that you have in the SNFs where you have the facility collecting the MDS data, for which they get paid.

DR. NEWHOUSE: So maybe the first point should be a point about auditing, which we can save the discussion until we get there. But then this could come as a comment but with a proviso about the speed that one went to refine would depend upon what one found, in terms of the accuracy of the data.

You tell me, has HCFA done any kind of validity checks of the OASIS data?

DR. KAPLAN: Yes, they have. They've done reliability and validity checks on the OASIS data.

DR. NEWHOUSE: But not in a context that they're paying on it. Because they're not. That's my concern. We know that this has been a problem with hospitals. That's got to be a more favorable case than this.

DR. LAVE: But wouldn't that suggest that you then want to wait to refine them?

DR. NEWHOUSE: That's my proviso.

DR. LAVE: My provision would be that you would revise it after you had a couple of years of data based on this system, because then you would pick up the responses. Revise it later rather than earlier.

DR. KEMPER: You might want to do both, certainly the later. I think the issue here was the fact that they were developed with fairly small samples and some of the cells were actually less than 50K.

DR. NEWHOUSE: Yes, that's right. That's fair.

DR. KEMPER: So that's a sort of separable short run issue.

DR. LAVE: But is this a feasible recommendation again, giving the timing?

DR. NEWHOUSE: I thought they were getting more data.

DR. KAPLAN: They basically said in the rule that they were going to make an effort to add more OASIS data so that they could get those cells -- the N in the cells.

DR. LAVE: So it's a feasible recommendation under the time frame.

DR. KAPLAN: I think that's the initial payment rates because the cells are small and then the refining, the payment weights over time, I think your and Joe's point is well taken.

DR. KEMPER: We do expect upcoding based on past experience. What needs to be in place to monitor that and think about updates? Is the needed information available to

do the updates, particularly since I would guess there would be a fairly powerful short run effect of the upcoding?

And I think that needs to be distinguished from the effect on actual resource utilization, which also probably will be pretty powerful but might lead to an update recommendation. And it's going to happen very quickly. So is the information going to be available to monitor that and be in a position to make an adjustment?

DR. WILENSKY: When you and I think Rand also independently did some assessments?

DR. NEWHOUSE: No, I was Rand.

DR. WILENSKY: -- on the DRG upcoding.

DR. NEWHOUSE: We started in '86, as I recall.

DR. WILENSKY: Was it information?

DR. NEWHOUSE: It accepted the chart as the gold standard, so it really goes back to -- and it worked off randomly pulled charts from around the country. So it goes back to what you have in my earlier comment, where is the home health chart the same kind of gold standard the

hospital chart was?

DR. WILENSKY: Even if it isn't, what are you going to use?

DR. LAVE: I imagine that the data in OASIS is going to come right from the chart.

DR. NEWHOUSE: I think it is, but if the chart says three ADLs and you go back, that's what you have. I mean, the PPS coding thing was, for example, going back to having coders at the super-PRO recode both contemporaneous and older records as an indication of true change, so they had the standard.

Now as I say, it turns out for example, they found a lot more tracheostomy the second time around because it turned out the second time around there was a DRG for that. The first time around there wasn't. And even the expert coders didn't code tracheostomy. But it was there in the chart that it was done.

So if you go back to the chart here and it says three ADLs, it's three ADLs. You're not going to be

distinguishing coding creep from the true state of the world.

MS. RAPHAEL: I think there are two separate things. I think the charts are very good source documents because you have progress notes and every time you interact with the patient, either in person or over the telephone or with the physician, you chart it. So they are quite, I think, specific. But it won't address the issue at any point of whether or not, on that particular day, the person actually had deficiencies in three ADLs. There's no way of ever knowing that, the clinician's judgment.

DR. NEWHOUSE: That's what I think, too.

DR. KEMPER: But I guess even if we can't measure the degree of upcoding, it seems to me that if people do upcode, then what that will mean is that the resource use within the rate cell will go down presumably, just as a result of the --

DR. NEWHOUSE: No, you can't. People will be shifting all around to different rate cells. They'll just

be moving all over the place.

DR. KEMPER: But the net effect will be that the payment rates are too high relative to the total resource use.

DR. NEWHOUSE: The net effect is that the total payments will go up.

DR. LAVE: But when you revise the weights.

DR. KEMPER: That's what I'm trying to get at.

DR. NEWHOUSE: The only thing I can think to do is to just make some arbitrary assumption that the true case-mix change could have been or was X, half a percent, a percent, or something. And that everything else is coding.

DR. WILENSKY: But I think at this point what we ought to do is -- there's no reason for us to make assumptions of that nature. What we ought to do, with regard to the commenting on this letter, is just to indicate this is an issue of concern. HCFA needs to be aware of this potential and be prepared to monitor. If it appears that upcoding may be going on because of what happens with both

the pattern and total expenditures in this area, we'll make further recommendations.

But I think at this point, since we don't really have an option but to assume that the patient's record is a reliable standard, or at least there certainly isn't adequate rationale to try to think of something else much more intrusive or expensive without knowing what happens.

DR. KEMPER: I guess what I was suggesting is we think about -- put ourselves in the position of two years from now having to recommend an update and ask what kind of information would we want to have to do that. And that's what I'm not...

DR. WILENSKY: Okay. I guess if you have suggestions that's fine to do, in terms of additional information.

DR. NEWHOUSE: We presumably have some baseline distribution today across the HHRGs. So two years from now, that distribution will change in some way, shape, or form. And it if changes in a way that people look to be in a

markedly worse condition, then the issue will be how much of that is just coding and how much of that is that people are, in fact, in worse condition?

DR. WILENSKY: It's the kind of issues that have been raised with the 15 minute evaluations on the physician fee schedule. If you see things that don't appear to make sense, that you think it may be reflective of a coding incentive, then we can try to make some response. I just think at this point what we can do is to highlight it, although I can't imagine HCFA is not painfully aware of this possibility, that this is something to try to think about how you're going to monitor in the future.

Sally, did you want to make any response?

DR. KAPLAN: My thought was that, the comment we're kind of skipping around, but one of the things that we expressed concern about at the last Commission meeting was asking physicians to confirm the group assignment. I don't know that that might have been or might not have been one way that they hoped to impede upcoding, was by having the

physician actually confirm the HHRG, that they would do that.

Now I don't think that it's feasible for physicians to confirm the HHRG assignment, but it could be possible that they could confirm number of ADLs, et cetera, et cetera.

DR. NEWHOUSE: Has HCFA been silent on what they're expecting from the physician?

DR. KAPLAN: All they said is that in the rule it says that physicians will be required to confirm the HHRG group assignment. It doesn't really explain why they're expecting that or how they expect physicians to be able to do that either.

MS. RAPHAEL: A little real world here, but even with physicians in ADL kind of estimations here, I think it's really hard. You see someone who's had a hip fracture, they're seeing an orthopedist. The orthopedist may know that they aren't ambulatory or they have problems transferring. But how is that person going to know about

meal preparation and medication administration?

It's just not feasible. So I just don't think that's going to work in practice.

DR. WILENSKY: I thought we had already reflected our concern.

DR. LEWERS: I thought we killed that already.

DR. KAPLAN: We did kill that. We did kill the HHRG assignment, but my point was that maybe whether it would be feasible to ask the physicians to confirm ADLs, et cetera. But according to Carol, no.

MS. RAPHAEL: I don't think it's workable. You have to see someone in a home setting to really see how they can function.

DR. LOOP: It's already in your letter. I agree with it, that physicians, it's beyond their responsibility. But if HCFA presses this, you can ask which physician. Because obviously the orthopedist who treats the hip fracture is clueless. But there are physicians associated with post-acute care and they could do this.

DR. LEWERS: But there aren't medical directors in your units, are there?

MS. RAPHAEL: Yes, there are medical directors but it would be hard for them to see all of the patients in a home setting.

DR. KEMPER: One other area in the comment letter, I think it would be useful to emphasize the need for quality monitoring and reporting on this, particularly focusing on the enteral feeding and the decubitus ulcers and the adequacy of therapy. Those three areas are areas where they're in the payment system and you worry about quality effects related to payments on those.

So I would want to stress the quality monitoring in the letter.

DR. WILENSKY: Any other comments?

DR. NEWHOUSE: There's a comment about use four or fewer visits as a threshold. In the spirit of the blend, although I don't think it will matter a bit, I would rather say four or more. That is, I would rather have the partial

payments, if they were going to go anywhere from four, go higher not lower.

Then I guess my question for you, Sally, is you're going to circulate a revised letter to us? Because obviously there needs to be language about where we think the system ought to be going in the future that really isn't here now.

DR. KAPLAN: Yes, I definitely will. I thought I would do it by e-mail, if that's appropriate for everybody.

DR. NEWHOUSE: Yes, I think it has to be. This thing is due before we meet again.

DR. KAPLAN: Right after Christmas. Also I wanted to add one more thing, if I may.

We are adding a comment on beneficiary education which is not in the comment letter. It will be included in your next draft and you can comment on it. Thank you.

DR. WILENSKY: Let me open the session up for public comment before we break for lunch.

DR. TOLLER: Good afternoon, my name is George

Toller. I am a house call physician and I'm president of the American Academy of Home Care Physicians. I've been very interested in your discussion.

I'd like to talk about two things. One is a short-term issue and one is a longer term issue. We agree that physicians should not be in a position where they're certifying the HHRGs. I don't think that most agencies actually know how that works. You put it into a computer program and a number pops out. I don't think the physicians actually would understand that concept.

However, I do think that we are in a position to certify the medical care plan, as we currently do, to talk about the physical therapy and other aspects of care. And I would hope that that would continue as part of our obligations in home care.

The second is a longer term issue and it's something that Dr. Lewers had alluded to, and that is the issue of medical direction in home care. This is the fastest growing sector of medicine and unfortunately

physicians have had a very minimal role in the development of regulations and policies and the practice of medicine at home.

I would like to ask you all if you would consider as a future date, perhaps a target in a couple to three years, that medical direction become a part of home care. That would give us some time to train a cadre of physicians in this aspect of care and perhaps get physicians to make more house calls, as I think most people would prefer to be cared for at home rather than be institutionalized.

So if that might be, as part of your comment later, we'd greatly appreciate that. Any questions about that?

DR. WILENSKY: Not unless individuals have a comment they want to make.

DR. TOLLER: Thank you.

DR. CASEY: I'm Don Casey. I'm an internist and director of Medicare health care quality improvement for the Maryland Medicare peer review organization. Dr. Wilensky,

if you don't mind, I'd like to just give the Commission a minute update about what we're doing in terms of quality monitoring in the skilled nursing facility arena.

Right now we're involved with a pilot project as part of a separate contract with four other states. We're actually down the road a bit towards developing a systematic assessment of quality, using the MDS data warehouse. We're dealing with some fundamental issues. I'll just tell you briefly about some example of this.

We're taking some crosswalk combinations of both MDS, specifically ADL data, and attempting to crosswalk it with functional status measures in high RUG categories for patients admitted with stroke and hip fracture, and following them through time as best we can. So there are some fundamental issues, including data integrity and consistency, that we're working with. But thus far it seems as though that's not as big of a problem as you might imagine.

However, I think that what's very interesting is

this whole notion of interaction between data elements -- and Dr. Lewers, I think, will appreciate this example of assessing weight loss in the context of both nutritional status and fluid status. And so just interpreting weight changes can get rather complicated quickly.

Our plan is really to, from our analysis, develop some focused interventions in the potential outlier facilities. And also help to look at upstream and downstream issues. We're focusing right now mostly on the post-acute side of the hospitalization, but we're also attempting to implement this in long-term care.

Just as an example of the upstream and downstream issues, one of the things we're starting to identify is the difficulty in getting good information about mood and cognitive status in some of the patients who are coming into long-term care facilities. And you can imagine the impact that might have on a rehab outcome.

We're also more recently going to move into the home health arena, just so you know this. We're going to

hopefully take some of the lessons that we've learned in the evaluation model with MDS and see if we can replicate that using OASIS data, as well, although I can't give you as much detail about that at this point.

The final thing I'll say, clearly, is that the infrastructures for quality improvement in these arenas are fledgling compared to other, more traditional, settings. And challenging, especially for those who claim, at least, to be resource constrained, as most people do.

And finally, I think helping to identify and monitor some of the agency issues of the new reimbursement schemes for upstream and downstream providers would be, I think, an important task of all of this, to integrate and look for changing patterns of behavior, I guess.

DR. WILENSKY: Thank you.

MR. ELLSWORTH: My name is Brian Ellsworth with the American Hospital Association. I spoke last time about both of these issues and I'd like to just briefly again address a couple of issues about the quality and then about

the home health prospective payment.

As regards the quality system, I would point out, first and foremost, that these instruments, particularly the MDS for SNFs and the OASIS for home health care, were developed for quality purposes. They have migrated to a payment purpose. The staff person pointed out that in the case, for instance, of the MDS it's 300-some-odd items and only a subset of them are used for reimbursement. Similarly with OASIS, it's 79 items and 19 of them are used for reimbursement. So there is a clear question in our minds about the need for all of this information and the burden that it's imposing on providers.

Additionally, there's also a clear question about this notion that that the definitions are different across the settings. I think we'd be very supportive of some standardization with an eye towards reducing the net burden of these instruments. It appears to be doable.

There are ways to develop a common core, but also to kind of reduce and be smarter about what the information

is that has to be reported on those forms. That's not to say that certain information might not be useful for providers to keep, but the question is how much do they have to report on certain forms and then manage that information all the way through the system. We think that there are ways to be more creative about leveraging these case-mix systems and these payment systems to actually reduce the net amount of information. We will be very pleased to work with staff to give some specific ideas in that regard.

As regards the home health prospective payment, we'd like to address two issues, the low utilization payment adjustment and this issue of stinting. As regards to the low utilization payment adjustment, one of the reasons why there is potentially a payment discontinuity between four visits and five visits is that the low utilization payment rates are too low. They are based on the average costs per visit across a whole range of episodes when, in fact, a low use case has a lot of costs due to admission and discharge that both would be within a four visit episode. Those fixed

costs would be a much higher proportion and, as a result, those rates should probably be raised.

This will not necessarily increase outlays because they carve out the rates later on in the price calculation. So one way to smooth out that discontinuity, if you will, would be to raise the LUPA rates and smooth that payment differential between four and five visits and, in turn, mitigate any incentive to increase that extra visit.

Secondly, as regards this whole notion of stinting, I think that as you look at this issue, you should really think about a targeted approach. It's not clear that there will be much stinting on a short duration case, a say two-week episode of home health care with a very clear cut treatment goal. And similarly, on long-term chronic care cases, if in fact there was stinting it's hard to believe that the beneficiary would stay with the agency and not switch. And almost by definition, a long-term case involves chronic repeated care.

So I would urge that as this issue is examined,

that there may be ways to target the efforts, in terms of looking at this question and blending incentives.

Thank you.

DR. WILENSKY: Thank you.

MS. ZAHLER: My name is Carolyn Zahler. I'm with the American Medical Rehabilitation Providers Association. We had just sent you all some information regarding the MDS-PAC that we are quite concerned about.

We laud the objectives you all have in trying to look at patient characteristics and what happens in terms of outcome and treatment across these various sites, and the knottiness of that particular problem without creating a tremendous burden for providers.

We recommended that, with respect to the rehab PPS, our little corner of the world, that the MDS-PAC items that are not related to payment be suspended from being implemented at the time the prospective payment system for rehab goes into effect. So that these issues of quality and outcomes can be looked at across the multiple sites.

The MDS-PAC was originally intended, we were told, to be used across multiple sites at the time it was first implemented. That does not look like it's going to happen now.

Our second recommendation regarding MDS-PAC, and slightly different from your broader post-acute care initiative, is that if the MDS-PAC is to be used, that it collect the data that supports the FRGs and appropriately categorizes patients into those FRGs. From our examination of the tool, as we put in our documents, that is very much an open question right now. We suggest that not just the face value of the instrument be looked at, but also that it be tested using both the MDS-PAC and FIM data.

Thank you very much for your time.

MS. BENNER: My name is name is Mara Benner and I'm with the Home Health Services and Staffing Association. I just wanted to comment on a few things.

We have done an initial review of the prospective payment system. We feel very strongly that it's certainly

under a very short time frame, and we do recognize that HCFA has very little opportunity to make significant changes to this. We're looking at the final rule in July and both the fiscal intermediaries and home health providers will have to make the changes within a three month time frame to meet the October 1st deadline.

Therefore, the industry has felt very strongly that we need to move to PPS as quickly as possible, since the interim payment system is a very flat system. So at this point, we're supporting a complete transition.

Although we also recognize that the magnitude of these changes could be very harmful to the industry because all home health agencies will have to undergo this system as of midnight October 1st, 2000. Therefore, one of our considerations or one of our recommendations is to also consider the need for significant cash flow to be able to sustain the agencies through these changes. We feel that that's going to be a significant problem considering the fact that the periodic interim payment system, PIP, is no

longer available to agencies, as well.

A few other quick comments, is that home health agencies do support the 60-day time frame, specifically because there are guarantees or safeguards to those 60-day episodes. That is, the physician recertification and also the requirement for the OASIS to be done at that point.

We also agree very strongly with some of the comments made by Brian on both reviewing the need for all the OASIS information. There's 19 questions with OASIS that are required for the financial PPS, and so we'd like consideration as to whether or not we need to continue with all those OASIS requirements.

And we also agree with him regarding the per visit rates. They do need to be increased because of the high intensity of care that is done within those first few visits for many patients.

Also, we agree with the comments made regarding physicians requirements. We feel that that may be a significant burden and that it may actually decrease the

access to the home health benefit. So we believe that maybe we should have the role of the physician looked at more strongly, but certainly not mandate that they have to certify the AD groupings.

Thank you.

MR. CALMAN: My name is Ed Calman. I'm with the National Association of Long Term Hospitals. I'd like to make just two points here today.

With regard to quality measures, I would hope you would pay close attention to intra-site reliability. Cases can code the same but use different resources between sites. And if you don't account for that variation then you may come to wrong conclusions concerning substitute of patients and payment.

We have the occasion, in working with the MDS-PAC, to code multiple patients coming into the long-term hospitals who are medically unstable, for example, with a stroke, and then leaving when they were better, healthier, going home. And they coded the same.

We therefore have concerns about the MDS-PAC's ability to properly reflect medical instability, and particular physician driven resource use of hospital level patients.

The second point I would like to make is as you look at integrated payment systems, you should understand that if you move towards a bundled payment system, then providers will have incentives, which I cannot really understand, to put patients in different settings. And that will affect benefit levels.

Right now, Medicare days goes with the certification of a facility. In the post-acute world you have, as defined by policymakers, you have hospitals which have one bundle of benefit days and copayment amounts, and you have SNFs, which have a different number of benefit days and different copayment amounts. Bundling will create incentives for providers to put patients in these different settings on a different basis than now, and that will affect the available benefits to patients.

So therefore, as you go down this road, looking at integration, one thing I would hope you would look at or consider is the effect on benefit days, coinsurance amounts, and whether to achieve the bundled payment, whether the benefit package must be changed.

Thank you.

DR. WILENSKY: Thank you.

DR. ROWE: I want to make just one comment in response to one of the comments. We don't ordinarily do this, but I think it's important.

One of our colleagues here, I think the representative from the American Hospital Association, said that we shouldn't be concerned about stinting because, I think he said, it would be hard to imagine that the patient wouldn't change the provider if these services being provided over long-term really weren't satisfactory.

I would hope my fellow commissioners would consider that many of these patients might not be sophisticated enough to make that judgment. They might have

cognitive impairment. They may not have options to change. They might not know how to change.

I think we have some responsibility for not letting the market determine all those resources. I'm just a little concerned about that.

DR. WILENSKY: In general, commissioners, although we don't as a practice make it a point to comment or respond to public comment, any time you feel it's appropriate or something's being raised that you don't understand, you certainly ought to feel welcome to in fact make some response.

DR. LAVE: Can I make another response in response to the comments? That is, I was intrigued by the comments on how the payment rates were being sent for the four LUPA days. So maybe Sally, when you revise the letter, you might make some assessment of what those payment rates are, relative to the costs. I think that would be helpful in whether or not we want to comment on that.

DR. WILENSKY: Any other comments? It is close to

12:30 as opposed to 12:00. Why don't we reconvene at 1:30?

[Whereupon, at 12:20 p.m., the meeting was recessed, to reconvene at 1:30 p.m., this same day.]

AFTERNOON SESSION [1:37 p.m.]

DR. WILENSKY: Stephanie?

DR. MAXWELL: Good afternoon. Today I'm going to describe the provisions affecting outpatient therapy services that are in the Budget Act that was just signed a couple weeks ago, and then I'll bring up two recommendations that you might want to consider in light of the new provisions affecting these services.

You've seen this slide before, of course. These are the four provisions affecting outpatient therapy services that were in the BBA in 1997. The new budget law deals with the last two provisions on the slide.

Most of the attention over the last couple months in the fall and the summer regarding outpatient therapy has focused on crafting some alternatives to the $1,500 caps. This slide shows the total annual speech and physical therapy payments of those users that had more than $1,500 of services in 1996.

Now options to raise the caps and/or have an

outlier policy were the most popular options and they would have been the easiest to implement. Now raising the caps would have helped those only at the very low end of this of this distribution. Having just an outlier policy, on the other hand, would have helped only those at the very high end. In fact, those that are even higher than what's on the slide. In the end, the BBRA simply lifted the caps for the next two years.

This slide and the next one lists the five provisions in the BBRA. Specifically, the BBRA places a moratorium on the caps for the years 2000 and 2001. The moratorium also applies to services provided by the independent therapists.

The next two provisions require that the Secretary conduct studies on the medical records and on the claims regarding outpatient therapy use. The BBRA specifies that the medical records review should pay particular attention to the SNF Part B users, and that the claims analyses should compare utilization in '98, '99, and 2000. In other words,

in the year prior to the cap, the year of the cap, and the year when the cap was lifted. In addition, that covers the first year, '98, when cost-based payment policies were still in effect, and then in '99 and 2000, of course, when the fee schedule was in effect.

The last two provisions of the BBRA relate to the coverage report that the Secretary is slated to submit to the Congress in January of 2001. First, the BBRA adds functional status to the list of factors the Secretary is to consider in classifying users of outpatient therapy services.

So between the BBA and the BBRA, the Secretary is required to come back with recommendations on a coverage policy for these services based on classification of individuals by diagnosis, functional status, and prior use of inpatient and outpatient or ambulatory services. In the same report, the Secretary is charged with including recommendations for assuring appropriate utilization of these services.

The BBRA provisions indicate a strong interest by policymakers to better understand the patients using these services and their utilization patterns, and to feed that understanding into the coverage development process. The next two overheads reflect some of the issues that need to be better understood. On this overhead, for example, we're reminded that the aggregate payments to these four main settings are quite disproportionate to the number of users treated in these settings.

But we also see that the vast majority of outpatient therapy users are indeed treated in the ambulatory settings. That is, in the hospital outpatient departments, the rehab agencies, and the CORFs. But 13 percent of these users may be very different from the rest. These include nursing facility patients who stay beyond their SNF Part A eligibility, those who actually exhaust their SNF Part A coverage, and those who are basically residents in these facilities.

DR. WILENSKY: Let me ask, is the

only reason you would be a Part B therapy user in the skilled nursing facility is because you've exhausted your 100 days? Is there anybody else that's in that category?

DR. MAXWELL: It could be those that -- people can lose their eligibility for the Part A without actually getting to the 100 days.

DR. WILENSKY: But they're people who have lost eligibility for reason or another.

DR. MAXWELL: Right, but the third category does include those that aren't necessarily Part A patients before that.

From our analyses we know that the annual payments of the ambulatory users for these services do differ by site among those ambulatory sites. By contrast though, the ambulatory users are quite similar in terms of these beneficiary characteristics. Further, the ambulatory users as a group look quite different from the SNF Part B users. For example, the SNF Part B users are more likely to be women; are poorer, as evidenced by Medicaid eligibility; are

older and have conditions that may be more disabling, such as stroke and other neurologic conditions.

These last two overheads list two possible types of recommendations that you might want to consider. They both deal with the issues that outpatient therapy services are furnished to what may be two very different groups of patients in terms of overall functional levels, prognosis, and therapy goals. And it also deals with the fact that Medicare doesn't now collect functional assessment information regarding these services. Further, there appears to be no single particular assessment instrument that is used commonly by clinicians or researchers in this area.

This overhead here suggests that the Secretary may need to consider designing separate coverage policies for the SNF Part B users. We've already seen in the design of the SNF PPS that it was not possible to develop a classification system that predicted the use or the need for therapy among the range of all the therapy patients in SNFs

based mainly on functional assessment and on diagnosis.

In terms of outpatient therapy services though, the BBA and the BBRA are asking for a coverage policy that works both for SNF users and ambulatory users of these services. This overhead is acknowledging that unless the new coverage policy is extremely general, it may be difficult to design a single policy that works for both the SNF users and the ambulatory users.

This overhead lists a potential recommendation about the collection of functional assessment information for the users of these services. As the paper in your briefing book states, Medicare should try to use for these services the functional assessment tools that the program already uses. Indeed, in last year's March report we discussed the MDS, the MDS-PAC, and the OASIS patient assessment tools already in use or planned for use, and we recommended that the program develop a common core of data collected across the post-acute settings.

For the outpatient therapy users in SNFs, the MDS

or the MDS-PAC may already be a sufficient tool. For the ambulatory users there probably are sections of the MDS or MDS-PAC that would be sufficient or nearly sufficient. Many clinicians note, however, that those instruments were developed for the inpatient population and some of the questions may be too blunt to pick up the variation in functional status and prognosis that probably exists among the ambulatory users.

Should that be the case, this recommendation suggests that the Secretary could draw upon the assessment tools that clinicians and researchers use in the ambulatory settings in order to design an assessment module that works for these users and follows on with basic information or a core of information collected across post-acute patients in the various settings.

With that I'll stop and open to any discussion.

DR. LAVE: I wonder whether or not it wouldn't make sense for us to withhold our recommendations until we get the information that is going to inform those

recommendations from the Secretary's study. It just seems to me that without knowing what the Secretary is going to find that we really can't say very much except that we could repeat our discussion from earlier which says we want to make sure that the database is in place, or whatever it was that we wanted, part of the long term care strategy.

It might very well be that we ought to think about some of these services in that context. But I find it hard to think that we could make recommendations in the absence of the information that's going to come from the Secretary's study.

DR. MAXWELL: There certainly are more report opportunities. The Secretary has a very large charge between now and January 1st and people probably would not be surprised if the report would possibly be late, and give more opportunities for recommendations.

DR. WILENSKY: Do we have any sense about what the likely timeframe is or is it just too soon?

DR. MAXWELL: HCFA is reassessing some of the

studies it had already started. For example, it had requested the OIG to study the medical records of the SNF patients and it is, over the course of this year, going to add medical record reviews of the ambulatory users. It's certainly going to be not possible to have all of the study information that's listed within the BBRA done before the coverage report. Indeed, the BBRA is asking for information off of '99 and 2000 claims as well.

It is also, as I understand it, likely that the Secretary will release an RFP to start some initial work on thinking about the coverage policy over the spring or summer. So it will put it on a tight timeframe.

DR. WILENSKY: Let me call on other people and maybe just think about whether we want to tie it back to this morning's discussion in terms of suggesting as they go forward they remember the other forums that are out there.

DR. LONG: Stephanie, how much money are we talking about that's paid by Part B for outpatient therapy?

DR. MAXWELL: In 1996 it was about $2 billion.

DR. LONG: So the SNFs got just under 30 percent of that?

DR. MAXWELL: Right.

DR. LONG: So about $600 million.

DR. KEMPER: I guess the two recommendations, as drafted, seem to be going in the opposite direction from some of the other things that we've said. The first one against the common data source and trying to get the post-acute policies all using the same kind of data and same kind of payment in the very long run.

And with respect to the MDS, we had talked about trying to think about FIM -- we had made a recommendation about using the FIM tool in SNFs to see if that could be used. It seems to me that's part of this discussion as well.

DR. MAXWELL: Actually the FIM tool will be implemented within, will be fully integrated within the MDS-PAC. The main point of that recommendation was to look at those specific elements that are within the FIM, or if you

will, the MDS-PAC and consider whether or not it's predictive of a discharge-based system rather than a per diem system, the way that the RUG is.

I also completely agree with your earlier point that the prior recommendations have emphasized the need to have common data collected across the sites. I think what some of this is trying to recognize is that there are going to be certain items and certain questions that are probably applicable to different settings that aren't applicable to others. And where there are common questions, they should be exactly the same. Where there are different needs, there should be modules that reflect that for the different settings. However, not every single setting should have to fill out questions that aren't applicable for their setting.

DR. KEMPER: It just seems to me adding a fourth post-acute payment and reporting both payment and reporting methodologies seems like going in the wrong direction.

Can you explain a little bit more about how this normative standards process and coverage policy development

will work? I don't quite understand exactly what's going to happen and how they will go about trying to develop this policy.

DR. MAXWELL: We actually decided to leave that out as a potential recommendation because, partly as Judy was saying, it is just so early on in the process. The normative standards are being developed by HCFA contractors for home health, partly reflecting the lack of a consensus about outcomes of home health services and the incredible variation of service use among different patients across the country. That process is in a fairly initial stage within the home health arena. We're adding even more initial stage regarding outpatient therapy.

It might be that the lack of consensus and the lack of understanding about what's appropriate or necessary for outpatient therapy might result in kind of a similar process. But kind of going along with Judy's point, it's a little early at this juncture regarding outpatient therapy to know if that's the case. After another cycle there will

be even more work by the Commission as well as by HCFA that would furnish a little more information about these services and the interaction of service use with other post-acute care settings.

DR. KEMPER: I guess I would just caution about waiting for the Secretary. We might want to be doing some work in parallel so that when we hear what the Secretary does we're in a good position to comment on it.

DR. LAVE: I just think we're not in a position to make a recommendation. I agree we should do more work.

DR. WILENSKY: Are we adequately preparing ourselves so that we will be doing this additional work? I agree with the sentiment that not only do we place ourselves in the position of not being able to respond on this issue if it happens that HHS, for whatever reason, delays their report. But we will also be in a difficult position, or may be in a difficult position to say very much in evaluating the report if we don't have some ongoing work of our own. I don't know how much we can do though reasonably on our own.

DR. MAXWELL: The process that staff is engaged in concerning linking the various claims across the settings is going to be a particularly valuable tool to help understand this.

DR. WILENSKY: I do think we need to be careful that we remember what our discussion of the morning in terms of being very cautious about the amount of information that we're requesting and to try to balance off its use and to try to strive for conformity with other data elements already being requested.

DR. LEWERS: Stephanie, I need some help.

DR. MAXWELL: So do I.

[Laughter.]

DR. LEWERS: I need you to educate me on the different definitions. I know we went through this once before, but to me outpatient therapy in a SNF and ambulatory therapy -- I just need you to bring me up to date on how that's broken out. Because I look at some of the charts you showed us and I wonder in '96 why some of those are on the

skew the way they are. It's got to be some definition. Can you help me?

For instance, cardiovascular surgery, SNF users, I'm not sure what the diagnosis was but most of your myocardial infarctions who are getting any therapy in that framework, in my opinion are done outpatient. Yet you've got those in SNFs. And hip fractures, I know a lot of them go to SNFs, but a lot of that continues in an ambulatory setting. So it's got to be definitions. Can you help me?

DR. MAXWELL: Partly, remember, that these aren't SNF Part A patients, which if you're talking about patients that go to SNFs following an injury or surgery in a hospital, these are not their claims.

You asked for definitions on these versus the ambulatory. Tell me if I'm understanding you correctly. Are you saying that partly it just doesn't make sense that these patients are --

DR. NEWHOUSE: Aren't these residents of nursing homes?

DR. LEWERS: That's what I'm trying to figure out. It was all claims though. I looked somewhere in here, it's all claims. So that wouldn't mean -- are you telling me they were all SNF patients?

DR. NEWHOUSE: No, not all, but they include them.

DR. MAXWELL: These are not any of SNF Part A patients.

DR. LEWERS: I understand that.

DR. MAXWELL: These are either patients that used to be Part A in a SNF and through the physician determination process they're not eligible for the Part A level of care any more, or actually they have exhausted their 100-day coverage level, or else they could also possibly be more of a resident in the facility. It's kind of an unfortunately accident that this range of patients are grouped in what you might consider independent or ambulatory therapy.

DR. LEWERS: But if you're saying a patient is a SNF Part B and is getting outpatient therapy, is that in the

SNF?

DR. ROWE: No.

DR. KEMPER: They're occupying a bed.

DR. ROWE: I thought I understood it. Let me tell you what I thought it was, and I maybe I'm wrong, too. The patient is in a nursing home. They need rehab. So what happens is the rehab facility -- instead of the patient getting in an ambulance and going off to a rehab facility to get rehab, the rehab people set up in the nursing home. And the patient has an appointment and goes down to the third floor, or up to the third floor, and goes to rehab, where they get therapy and that's billed as Part B Medicare.

That is, it is a nursing home patient, resident, who's residing in the nursing home, who may or may not, is probably not getting Medicare Part A payments at that point but can in fact have services billed Part B Medicare. Isn't that what this is?

DR. MAXWELL: Absolutely.

DR. NEWHOUSE: That's what I thought.

DR. LEWERS: I got that. Now do such a succinct definition of ambulatory. What's the difference in -- they leave the facility and go elsewhere?

DR. ROWE: Yes, exactly. The nursing home does not have a facility or make an arrangement with a rehab company, so the patient actually has to leave the nursing home and go to a place where they get the rehab.

DR. LAVE: No. Do you know that? I think you just know where the patient is residing.

DR. ROWE: That used to be common, and then these places started setting up in the nursing home.

DR. LEWERS: I know that.

DR. LAVE: I think this patient probably could have perhaps gone to an outpatient facility. We don't really know that. We know that these are patients who are residents of nursing homes. That's where they are residing. And they are getting therapeutic services. Some of those therapeutic services could be brought into a nursing home or the patient can be brought out.

DR. ROWE: That's my point.

DR. LAVE: The ambulatory patients are people who are residing in the community and who are receiving their services from a community-based provider or rehab or a CORF, and they are in fact -- so these users have to do with where the patient -- the skilled nursing facility is kind of a funny definition, isn't it, because it's both where they're getting -- it's mainly where the patient is residing, not really where the patient is getting the care.

DR. LEWERS: As I read the chapter I kept getting confused. I wasn't sure who was doing what and where. But I'll reread it again now that Jack has straightened me out.

DR. MAXWELL: In past chapters I've included appendices that describe some of these and I'll make sure next time to keep on including some of those. My apologies.

DR. KEMPER: Can you now explain to me the interface between Part A and Part B? Let's say somebody is a Part A patient and is a therapy RUG, then their therapy costs are included in the daily rate?

DR. MAXWELL: Right, and this is totally separate.

DR. KEMPER: And this is irrelevant. Now the physician decides, no longer eligible for Part A, for whatever reason. The next day they could get the same therapy service under the outpatient benefit?

DR. MAXWELL: Right, if the physician decides that they're no longer eligible but the patient decides to stay and basically pay through other services, Medicare still picks up the therapy payment through this role.

DR. LAVE: We're having a definitional problem here. My definition is that the SNF does not receive a payment. That the payment goes to a person who's providing -- who is the provider of the occupation therapy, who could be a rehab agency, right?

DR. MAXWELL: That's correct. Except for those patients are within the SNF column here.

DR. LAVE: So that the hospital OPD, rehab agency, and CORF have to do with where the community people are.

DR. MAXWELL: That's right.

DR. LAVE: The skilled nursing facility really only has to do with where the patient is. Then so this basically says that 24 percent of payments go to hospital outpatient departments, excluding any -- could they have somebody that would go into the facility? I'm a rehab agency and I send people into the facility. Where do I get picked up on this?

DR. MAXWELL: If you're a rehab agency and you're treating patients that are in the facility, then those patients and those payments come on the facility line.

DR. LAVE: On the facility line or the SNF line?

DR. MAXWELL: On the SNF line.

DR. LAVE: On the SNF line. So if I am a community agency, some care I give to -- if I give care to a community-based resident it appears on the rehab agency line. If I am the same facility but I give care to a person in a facility who is a resident of a SNF, it appears on the skilled line.

DR. MAXWELL: That's right.

DR. NEWHOUSE: If you give care in the facility.

DR. MAXWELL: That's right.

DR. NEWHOUSE: If the person comes to you, then it goes on the other line, as I understood it.

DR. LAVE: If I am in the facility and I get in an -- I'm a resident of a nursing home. I get put in an ambulette and sent to the rehab agency, which column does that payment go to? Does it go to the SNF column or the rehab column?

DR. MAXWELL: To the SNF column. The consolidated billing requirements for SNFs ensure that, that it must be billed through -- that there's a pocket of money just for that SNF.

DR. WILENSKY: Any further clarifications?

It makes it hard. They're using a different basis of classification, but I gather there isn't any clearer way to try to distinguish between these individuals.

DR. LAVE: But where you really pick up the difference then is if you come to this column, because

you're talking about the differences between community-living people and --

DR. MAXWELL: That's right.

DR. WILENSKY: I can't recall -- you say it in the chapter, but it may be that repeatedly focusing on that distinction as you're going through the discussion would be helpful to remind us that in all of the cases other than those that are labeled in the skilled nursing facility, these are community-based people who are going various places to have their care, their therapy. And otherwise they are labeled, if they're in a skilled nursing facility, that's where they are.

DR. MAXWELL: Okay.

DR. NEWHOUSE: I'm thinking about how this is going to be in the report. What I take away from this is that the main point is the Secretary, in formulating the new policy should take cognizance of the fact that there's really two rather distinct populations here, or at least two populations I should say, and that's what we're calling

attention to. Which I don't know that that has to rise to the level of a recommendation, but that's what I take away now as the main point of our chapter.

DR. WILENSKY: It seems to me that where we are is where we recommended, so we have to pause and wait for the next step to happen. What we've been saying is that the problem with this therapy cap is that it doesn't differentiate according to the clinical or functional characteristics of the patient, and therefore, the cap has been arbitrary. Congress has now directed the Secretary to prepare a report that would allow you to develop a system that varies according to the functional characteristics of the patient.

So other than making really some minor additional recommendations like the importance regarding these two, at least two groups, as being very different populations, and trying to make the information collected as consistent with other data collections as possible, and to minimize the burden on the agencies, there really isn't a whole lot more

to say right now.

DR. LAVE: I had a question, and I think I know the answer to this question, but I just wanted to be sure I understood it. This relates back to the home health issue. If I am under home health and I need physical therapy, I receive that care through the home health agency; is that correct? But could I be on home health, be receiving home health and go to a rehab agency for some rehab? I mean, I was very curious about how that worked. And it has potential, obviously, for gaming under the prospective payment, so I was curious about that.

If I am under home health care and I need -- I believe I get physical therapy through home health, right?

DR. NEWHOUSE: Yes.

DR. LAVE: So I get that through home health. Suppose that I'm getting home health for some stuff, can I get physical therapy in a rehab unit as well?

DR. MAXWELL: As you did say, these three therapies in general are available in the home health

benefit and have been paid for under the home health rules, and recently under the IPS and will be paid for, therapy will be paid for under the home health PPS. We did hear anecdotally though, by clinicians under the IPS, that they did sometimes basically use up their IPS amount of money on skilled nursing services and sent patients to outpatient facilities for this therapy. That did not ruin their homebound eligibility because they were going for medical service.

DR. NEWHOUSE: So this is the analog of consolidated billing for home health, if I understand it right.

DR. LAVE: You could do the analog, but it's harder for the home health to do the analog because you're not residing in their home health facility. You can sneak out the door to a therapist.

DR. NEWHOUSE: Yes, but you could still bill that against the home health agency.

DR. LAVE: You could but we don't, right?

DR. MAXWELL: We heard that, purely --

DR. NEWHOUSE: We may want to ask HCFA to monitor that behavior as well in our comment letter on home health.

DR. LONG: If my son-in-law drives me to the OPD to get additional therapy.

DR. NEWHOUSE: Or any therapy.

DR. MAXWELL: I would think that there would be somewhat fewer incentives for that under the PPS than the IPS.

DR. LAVE: I think there would be more.

DR. WILENSKY: You could have a fixed payment. You have a fixed payment and zero marginal revenue as a way to unbundle.

Any further comments?

Okay, thank you.

Sally?

DR. KAPLAN: There are three purposes to this session. The first is basically to inform you about the timing of the first SNF update recommendation. The second

is to discuss the appropriateness of using a hospital update framework for the SNFs. And the third is to get the benefit of your insight into the depth to which the framework components should be researched.

The timing of the first update recommendation, a recommendation for fiscal year 2003, would be based on data from the first SNF PPS year. For hospitals, we traditionally have wanted to have cost reports for at least 50 percent of the facilities. If we make a recommendation for fiscal year 2002, it would be based on only 28 percent of the SNFs.

In contrast, the cost report data for 95 percent of the SNFs would be in our hands on March 31st, 2001 and we would consider, or you would consider, a recommendation in the fall of 2001 and publish the recommendation for fiscal year 2003 in the March 2002 report.

But also, I think it's important to remember that any behavioral change will be muted because 75 percent of the payment reflected in the cost reports we would receive

on March 31, 2001 still would be SNF-specific, rather than based on the national averages.

In the next slide I wanted to show you, basically really just to show you that the cost report data are based on a rapidly changing environment. We know that it's similar to doing update recommendations in the hospital world. But we also just want you to remember that there will be lots of structural changes, which I don't know that the shading shows up very much on that slide. But on your handout you will see that there are shaded boxes which are structural changes, and then the boxes that are unshaded basically are when the data would be available.

So we'll be trying to assess behavioral changes while everything is changing at the same time. Changes in the SNF payment, multiple changes in the SNF payments, transfer policies for hospitals, and in other post-acute settings. It isn't that this is any different than anywhere else, we just wanted you to be cognizant of it.

In talking about the update framework and its

appropriateness for SNFs, I'm going to go through the general elements used for the hospital update framework. In September, you agreed to use this framework for SNFs. I'll briefly discuss what we would do in the SNF world, and then identify areas which are more likely to be problematic. These are the areas where we'd like your input.

As you know, the Commission takes adequacy of payments into account. As part of the determination of adequacy, we will calculate Medicare and total margins for the SNFs from the SNF cost reports. Although we won't have margin data, we're working on other methods to determine payment adequacy, such as looking at access to SNFs.

The elements of the hospital update framework include the market basket forecast, which has six major expense categories: wages and salaries, employee benefits, contract labor, pharmaceuticals, capital related costs, and all other costs. The labor related share for fiscal year 1999 is 75.9 percent, which is higher than for a hospital.

The forecast error correction will be made two

years after the forecast was made, assuming that there are errors.

The scientific and technology allowance, for the hospital, S&TA includes only technologies that are FDA approved, affect between 5 and 75 percent of relevant beneficiaries and result in substantially higher treatment costs. If we did a comparable allowance for the SNFs, it would be intended to provide those facilities with funds to adopt advances that enhance quality and increase costs.

Standard productivity improvement factor, the Commission agreed to use .5 standard for a hospital update. We would like to know if you want to use a standard for SNFs.

The adjustment for site-of-care substitution is much less important for SNFs than for hospitals. For hospitals there has been a fixed price in one sector and a variable price in the other. SNFs might be on the receiving end of this behavior, but we don't believe they're on the giving end.

The next element is adjusting for the RUGS III coding changes, which adjust for the portion of change in coding that is not real change.

The final element is an allowance for within RUGS III group complexity change. We believe that this issue could be studied, if you decide that you want it studied, by examining MDS elements for patients within the same case-mix group.

On the next slide are the elements of the framework that staff thinks are most likely to be problematic. We need your comments on these issues and whether you want us to pursue them. Some of you have been discussing hospital updates for years and we'd like the benefit of your wisdom related to this.

DR. WILENSKY: Let me open it up for questions.

DR. NEWHOUSE: My first process question. You've got basically 15 months from the time the cost report year ends until the time that the data are available, which seems like a very long lag.

DR. KAPLAN: Because the SNFs roll into PPS according to cost report year.

DR. NEWHOUSE: No, no. I understand, but you've got 3/31/00 cost report year ends for the last SNF, which are the ones that rolled in in April '99. And then 15 months later the data are available.

DR. KAPLAN: That's what I understand is...

DR. NEWHOUSE: I think one ought to raise a question about why it takes 15 months, but -- I mean, I don't expect an answer here.

DR. KAPLAN: I can tell you that the SNFs have five months in which to file their cost report with the FI. Then there's a period for the FI to do whatever they do, and then to get into the system. But this is what HCFA says and this is also what other MedPAC staff said.

DR. NEWHOUSE: No, no, I'm not doubting -- the real issue is whether it should take 15 months. I'm not doubting that it does take 15 months.

Then a couple of substantive things. I'm a little

concerned about how we're going to measure upcoding. As I mentioned this morning, our study of upcoding on the hospital side took the chart as a gold standard. If the hospital is really claiming that these people are in a higher RUG, I would expect that to show up in the chart or documentation to be there that maybe wasn't there earlier to document that they would be in a higher RUG. Before nobody really cared, so they didn't put it in the chart.

Given the methodology we used in the hospital, we would have called that true change. But in fact, it could be coding change. That is, if we hadn't changed the payment scheme, the hospital would have gone -- it's the same patient.

DR. WILENSKY: But the fact that -- let me pursue that a little bit. It's true that it will show up as a change when, in fact, it was not a change in resources used but now more accurate coding than previously. Presumably, the earlier coding --

DR. NEWHOUSE: But it's going to show up as true

change in this because there's going to be more documentation that makes you think this person has more ADLs.

DR. WILENSKY: I understand that, but we have nothing but whatever existing baseline --

DR. NEWHOUSE: No, I understand, but that then leads me back to the issue of I don't think we're going to be able to tell very well what's real and what's coding. I don't see any way around that. We just not ought to fool ourselves that there's some magic tool out there that's going to let us make an adjustment.

The other two remarks are smaller. One is I don't know how much of the S&TA in the SNFs is attributable to pharmaceuticals, but it would seem to me to the degree that it is pharmaceuticals, we could measure that -- one could measure that reasonably well. It shouldn't be all that hard to find out what mix of pharmaceuticals SNFs are buying and how that's changed.

The other is the productivity factor. Again, it's

a judgment call. I would have thought that if you were efficient in 1996 that the technology in SNFs is not changing as fast as in hospitals and it's harder to increase productivity. It's more labor intensive activity. I would have thought we would want a somewhat lower bar for SNFs than for hospitals. But how much lower is a judgment call.

MR. MacBAIN: First, I can't tell you what a pleasure it is to see something we don't have to do anything about for two years. I'd like to encourage more reports like this.

For me, I don't have a whole lot of practical knowledge about skilled nursing facilities, so in answer to your question to what depth we want to sink to, having more information about S&TA expenses in skilled nursing facilities would help a lot.

I agree with Joe's concern about how do we look at productivity where really we're talking about labor productivity in a labor intensive industry in which the complexity of cases is probably going up. If anything, I

would expect to see productivity as we can measure it stay the same or get a little "worse." So I'd be cautious about applying the same logic we've applied to hospitals where if we don't pay it you'll get more efficient, as been sort of the rule. In SNFs I could see that translating into a deterioration of patient care all too readily.

So those are two areas that I'd like to see some real research on before we made any assumptions.

DR. KEMPER: Just stepping back for a minute to the whole update process, I think it would be useful to start out the update discussion with just some basic information on trends in Medicare expenditures by all the various categories, just to put this whole discussion in context, to see where the whole program is going and what different components are doing.

The second thing is on the site-of-care substitution, I think there's an analog to that in the SNF side, which is while there isn't an episode based payment, presumably some of the payment rates, the payment is above

the marginal cost of the patient and other cells the payment rate is below the marginal cost, just because we probably haven't got the payment rates quite right.

So there would be some incentive to discharge patients where the price is too low, the payment is too low, and vice versa for where it's too high. So there will be some incentives, and I don't know which way they come out, and that's an empirical question, just to get people out of the facility.

But I think there's also -- and I don't know what proportion of the SNF patients are what I would call permanent residents or residents who stay in the facility after they leave SNF eligibility, but it's pretty easy to shift somebody or could be easy to shift somebody from payment source either from Medicare to Medicaid or Medicare to private payment. And that is sort of the stroke of a pen, and there could be that form of substitution if we haven't got the payment rates right for the different cells.

So I think it's a different thing from the

hospital substitution, but it's a piece of analysis that might be worth looking at.

And on the technological advance and productivity, I agree that more needs to be done there. Just for starters, what kind of technological change were we talking about and where is the source of the productivity improvement? I don't see it so much on the nursing home, but that could be because I'm not aware of it.

DR. ROSS: Actually not so much a follow-up as a question. I did not follow you on the substitution here between payers and what we're concerned with there?

DR. KEMPER: I'm just saying that the payment system has changed, so for some fraction of the SNF payments they're really Medicaid nursing home residents who may have a temporary SNF episode or private pay patients who have a temporary SNF episode. I don't know what fraction that is, but for those patients they shift funding. They stay more or less where they are, but they shift funding sources.

DR. NEWHOUSE: We may be getting semantic here.

On the hospital side it was really unbundling of care by taking the last day or two and putting it out. Whereas, here it's more like the same patient may -- if you have to say the intensive RUGs are under-weighted, you may now treat that patient at a rehab rather than a SNF.

DR. ROSS: I thought he was arguing that they'd get shifted over to the private pay or to Medicaid, not that you get --

DR. NEWHOUSE: He also said that, but I --

DR. KEMPER: It's both.

DR. NEWHOUSE: But that's not really unbundling in the same sense that it was in the hospital side. It's an induced behavior change.

DR. KEMPER: No, but it's an induced behavior in response to the payment change, which might lead to an update response. That's all I was concerned about.

DR. LONG: It's not getting somebody else to do the same thing for which you are now being paid?

DR. ROSS: No.

DR. WILENSKY: Further comments?

MS. RAPHAEL: One thing to follow up on what Peter said that I would be interested in is -- and this is all anecdotal -- I'm hearing that lengths of stay are shorter now in nursing homes overall. And that a larger number of people are being discharged, sort of within a three month period, from SNFs. Now this is anecdotal, I have no empirical data.

But I just would be interested if we have any kind of trend analysis there?

DR. KAPLAN: We will have information on whether the lengths of stay have shortened since the PPS went in, but we're not going to have it today, or whatever. But that analysis is being done.

DR. ROWE: Only for the Medicare patients.

DR. KAPLAN: That's correct.

MS. RAPHAEL: Right.

DR. KAPLAN: But not the nursing home stay.

DR. ROWE: I think Carol was referring to --

DR. KAPLAN: Are you really referring to the nursing home patient? You're really talking about the long-term care patient.

MS. RAPHAEL: Right.

DR. KAPLAN: Not the Medicare patient. I know that fewer people are spending down in the SNFs, but I don't know that the length of stay is really changing. And that the occupancy rate is dropping, as there become more alternatives to nursing homes for long-term care, such as assisted living, increased waiver services.

DR. LAVE: The one question that I have is, that I went to a very interesting meeting where the discussion was that the admission rates for nursing homes had gone down, the people who were leaving the nursing homes are private pay patients going to assisted living, but also that the -- and this is going to get to where I was -- that the costs are going up and the costs are going up because of the shift to contract labor. That has to do with the extent to which, in fact, the markets are right.

So that would be a question that I would have, is whether or not one wants to think about that. I don't know whether this is as much a Medicare SNF problem or the resident SNF problem, but this, I was told, was a generic problem that the costs of contract care is much higher than hiring people. And that, as the labor markets get much tighter as a result of the robust economy that there is an issue.

So that's just something I throw out as something. Whether or not we ought to think about it, I don't know. It's not really an S&TA, but it is a change --

DR. NEWHOUSE: It's a wage index problem.

DR. LAVE: But you're not going to pick it up in the wage index because the balance between the contract and the non-contract labor in the market basket is --

DR. LOOP: Do you need an industry specific wage index?

DR. LAVE: So I throw that out as an issue that you may want to think about later, in terms of the update

factor.

DR. WILENSKY: You do, but the data doesn't exist.

DR. LOOP: One other thing that you're talking about scientific and technologic advances, in pharmaceuticals, though, the goal in SNFs is to use less pharmaceuticals not more. Now maybe you're talking about the costs of pharmaceuticals, but the goal ought to be fewer drugs, not more.

DR. WILENSKY: Not necessarily. To the extent that you have appropriate drugs -- I mean, you ought to use the appropriate level of drugs.

DR. NEWHOUSE: Even if they're fewer, they may be more expensive.

DR. LOOP: That's the point, I think, is that they may be fewer but they may be more expensive.

DR. WILENSKY: Are there any other comments or issues people would like to raise on this?

DR. KAPLAN: Thank you.

DR. WILENSKY: We're going to be shifting gears to

another comment. Let me ask for public comment on either of these two areas before we leave the post-acute area.

Okay, Dan?

DR. ZABINSKI: The analysis that I'm going to present today is intended to be part of the access to care chapter for the March report. I presented the work plan for this analysis at the September meeting and stressed analysis of how much beneficiaries' out-of-pocket spending on health care has changed over time.

It was also recommended at that time that I also analyze the persistence of out-of-pocket spending at the individual level and I incorporated that recommendation into the analysis.

Today I would like the commissioners to provide feedback on whether I've investigated the appropriate issues and on the methodologies that I've used.

The analysis has gotten much longer than I initially intended and currently investigates five issues. The first issue is how do Medicare beneficiaries and people

who are not eligible for Medicare differ in terms of financial liability. The purpose here is to provide a benchmark with which to compare the financial liability of beneficiaries.

The second issue is concerned with whether beneficiaries' financial liability on health care is increasing, decreasing, or staying the same in recent years.

Third, the degree to which a beneficiaries' out-of-pocket spending affects their economic well-being depends on whether the out-of-pocket spending persists for a long time or is variable. Therefore, I investigated the degree of persistence of beneficiaries' out-of-pocket spending as commissioners recommended at the September meeting.

Fourth, I looked into how the elements of beneficiaries' out-of-pocket spending on health care services has been changing in relation to each other. The intention was to give a sense of whether the services that contribute the most to high levels of out-of-pocket spending right now will continue to do so into the future, or if

other services will take their place. This can provide an early indication of where out-of-pocket spending problems might lie in the future.

Finally, as part of the access to care chapter, staff are analyzing how managed care enrollees access to care compares to that of beneficiaries in the traditional program. Now beneficiaries access to care, of course, is affected by their financial liability, so I investigated how financial liability differs between managed care enrollees and traditional program beneficiaries who have Medigap coverage.

I extended this analysis by thinking about how provisions in the Balanced Budget Act might change the difference in financial liability between the two groups.

I'd like to look at the issues in a little more detail. In regard to the first, I compared the financial liability for beneficiaries and the people who are not eligible for Medicare by comparing the percentage of their aggregate budget that beneficiaries spend on health care and

other budget items to the aggregate budget percentages for people who are not eligible for Medicare.

I found that beneficiaries spent a much larger share of their aggregate budget on health care than did the people who are not eligible for Medicare, which is not surprising. But the important question is on which of their budget items do beneficiaries spend a relatively small share? I was surprised to find that beneficiaries and those not eligible for Medicare spend very similar percentages of their budgets on housing and food. About the only budget item where those who were not eligible for Medicare spent a larger share of their budget is savings for pensions and other retirement plans.

Next, to investigate whether financial liability has been increasing, decreasing, or staying the same in recent years, I looked at how the percentage of income that beneficiaries spent on health care changed over the 1992 through 1996 period using data from the Medicare current beneficiary survey. I found very little change in the

average of this measure over that period, as you can see, on the very top row of numbers on the slide, where the mean from '92 to '96 is pretty similar -- in fact, statistically, they're not different.

However, I did find it interesting that there is a consistently very large difference between the measures at the median level and at the higher levels, say the 90th and the 95th percentile. Further, the difference between the median and the high values is even more extreme for low income beneficiaries, primarily due to coverage differences for those who have Medicaid and those who do not.

As I mentioned earlier, the degree to which out-of-pocket spending affects a beneficiary's economic well-being depends on how long the situation persists. To investigate this issue, I followed a cohort of beneficiaries that was alive from '94 through '96, and found that beneficiaries out-of-pocket spending typically stayed at about the same level throughout that period.

For example, on this diagram that I have here,

what I have is the beneficiaries' percentile ranges for their 1994 out-of-pocket spending in the very left-hand column. And across the top row I have their 1995 out-of-pocket spending percentile ranges in that row.

I'd like to really focus on the diagonal that goes from the very upper left to the very lower right of the matrix, which indicates the percentage of beneficiaries that are in the same percentile range in 1994 and 1995. What I'd like you to notice is that the diagonal values are the largest values in each of these rows.

This indicates that beneficiaries are most likely to be in the same percentile range in 1995 as they were in 1994. I found a similar result when I compared their '96 out-of-pocket spending to their '94 out-of-pocket spending. Not quite as clear cut, but it looked pretty similar.

What these results imply is that beneficiaries experiencing financial hardship from out-of-pocket health care spending are likely to face that situation over multiple years.

In regard to the fourth issue, I found that beneficiaries out-of-pocket spending between services that comprise total out-of-pocket spending changed some from 1992 through 1996. Specifically, some services that had large shares of out-of-pocket spending grew very quickly and others grew more slowly.

At the same time, the services with smaller shares grew even more quickly than all of the services with larger shares, but those smaller services are so small in relation to the larger services that they'll probably maintain their smaller status into the future.

On the final issue, I found that managed care enrollees have much less financial liability from health care spending than do beneficiaries with Medigap coverage. From 1992 through 1996 managed care enrollees, on average, spent much lower percentages of their income on health care and had much less out-of-pocket spending on health care than did Medigap beneficiaries.

Further, the difference between the two

populations really didn't narrow during that period. However, there are BBA provisions that will reduce payments to managed care plans which could induce them to increase their premiums and/or their cost-sharing, which would increase the out-of-pocket spending for enrollees.

Now there are provisions on the Balanced Budget Refinement Act which will soften the effects of the BBA provisions, but the qualitative effects of the BBA provisions should remain.

The provisions I'm referring to include the new risk adjustment system, the statutory reduction in the nationwide fee-for-service growth rate before using that adjusted growth rate to update local payment rates, and a new formula for determining local payment rates as the maximum of the floor rate of 2 percent increase in the previous year or a blend of local and national payment rates.

All in all, it looks like the impacts of these provisions might already be being felt. For example, HCFA

indicates that plans are increasing co-payments for prescription drugs and that the number of beneficiaries with access to a zero premium plan is decreasing.

Finally, the impact that managed care coverage has on beneficiaries' access to care may be even more pronounced than what my out-of-pocket spending results indicate, because there is evidence that managed care enrollees who move from traditional Medicare to managed care were more likely to lack supplemental coverage than beneficiaries who stayed in the traditional program.

For example, in 1997 MCBS data show that 27.4 percent of the managed care enrollees who were in traditional Medicare the year before did not have supplemental coverages the year before. At the same time, only 12.2 percent of the beneficiaries who stayed in the traditional program in 1997 and who were in counties with at least one Medicare risk plan lacked supplemental coverage.

Now the disparity between managed care and Medicare may be due in part to managed care enrollees being

likely to have low incomes than Medigap beneficiaries. In 1996 I found that 25 percent of managed care enrollees had incomes below $10,000, but only 18.7 percent of Medicaid or Medigap beneficiaries in counties with at least one Medicare risk plan had incomes below $10,000.

That's all I have for today and now I turn things over to the commissioners with the reminder that I'm looking for feedback on whether I've investigated the appropriate issues and on the methodologies that I've used. Thank you.

DR. NEWHOUSE: I have a methodological point, and then a question. On the percentage of income spent on health care, you have in the footnote that you, for married couples, divided income by two. You could have used, I think the BLS equivalent scales, that will basically account for the fact that two can live more than twice as cheaply as one because of economies of scale in housing.

I don't know how much difference that's going to make in the percentages but it could potentially make some difference. Not over time, but in the levels at each point

in time.

DR. ZABINSKI: What is it about 1.7 instead of dividing by two?

DR. ROSS: 1.4.

DR. NEWHOUSE: So that's a substantial effect, depending on how many are married.

DR. ZABINSKI: One point on that. I don't exactly recall where I read this, but I did read somewhere that someone who once used 1.7 as an adjustment factor like --

DR. NEWHOUSE: Whatever it is, it's less than two and conceivably substantially less than two.

DR. KEMPER: But on the other hand, then things don't add up.

DR. ROSS: You don't have dollars anymore, you have equivalence dollars.

DR. NEWHOUSE: But if I'm trying to make sense out of percentage of income, and I'm comparing households of different compositions, then I ought to use an equivalent scale. Otherwise I'm adding apples and oranges. I've got

what I've got here, which is dividing by two. I mean, I'm going to divide by something.

My question for you is you used both the consumer expenditure survey and the MCBS for '96. Did you compare the consistency of your results?

I'm sorry, the results that are here are you used one for one, table one for another. But did you look at the absolute amount of spending in those two?

DR. ZABINSKI: My absolute amount -- here's what I'll tell you. The mean out-of-pocket is lower in the CES, which isn't surprising. I think that's due to the fact that in the MCBS they cross-referenced the beneficiaries responses with the claims information and they can impute data using that method. But in the consumer expenditure --

DR. NEWHOUSE: Wait a minute, how can they impute it if they don't know Medigap? And they know Medigap coverage? I guess they do. They know the details of the Medigap coverage, or employer-provided coverage?

DR. ZABINSKI: That I'm not sure.

DR. NEWHOUSE: Because they'd have to know that to get to out-of-pocket.

DR. ZABINSKI: One thing they can find out though, is if somebody forgot to mention some procedure or something like that. They can investigate claims information and work from that.

DR. NEWHOUSE: Only if they ask for out-of-pocket on the survey by procedure, which I don't think they do. I think they just ask you for total out-of-pocket.

I'm curious about the consistency.

DR. ZABINSKI: Well, the CES does not do any cross-reference like that. That's one thing I do know.

DR. NEWHOUSE: I understand that. How much lower was the mean?

DR. ZABINSKI: It was a fair amount. My recollection was right about 25 percent lower, and that's not -- I mean, one thing I do know is reading work by Jason Lee, he did some work with the CES and the NEMIS at the same time. The NEMIS and CES were even more extreme in the

difference between the two.

DR. NEWHOUSE: You just might note that the share, when you use the CES data, could be understated, assuming that we think that the MCBS is the more accurate source.

DR. WAKEFIELD: Just a quick question on that. Your bullet stating that managed care enrollees have much less financial liability compared to enrollees who purchased Medigap. The projection then is that you expect that the gap between financial liability for managed care enrollees compared to Medigap to narrow based on BBA provisions?

DR. ZABINSKI: Yes.

DR. WAKEFIELD: And that's expected to narrow. Nothing else would factor in there.

DR. ZABINSKI: There could be other BBA provisions that could increase the Part B premiums on the Medigap beneficiaries, but that probably won't be a big effect.

MR. MacBAIN: It's the likelihood of increases in premium for Medicare risk plans, Medicare+Choice, and the reduction in the supplemental benefits, particularly drugs.

DR. WAKEFIELD: Just offline, Dan. I won't take the time of my colleagues, but the last bullet on page six, I could sure use an explanation of what that means, but I'm probably the only one who doesn't understand that, so you don't have to do it now. But I'd like an explanation.

DR. ZABINSKI: Let me just say one thing though. I wrote that at the last minute and then a couple of days later I picked it up and I said what does that mean? So I looked back at the BBRA provisions and I had to rethink about it and talk to colleagues who more about it.

DR. WAKEFIELD: But now you know what it is.

DR. ZABINSKI: I have a better feel for what it means.

MR. MacBAIN: A few points, help me understand. First of all, looking at your matrix, am I reading these correctly to say that roughly half of the people in the sample stayed in the same cluster, whichever percentile cluster they were in?

DR. ZABINSKI: Right.

MR. MacBAIN: Of the remaining half, if you were in the other half, it looks like there was a greater likelihood that you would drop down one or more clusters than go up one. So I'm not sure how strong an argument that makes, at least to my non-statistical mind, in terms of persistence.

You could say that the greatest likelihood is you'll stay the same or go down, versus staying the same and going up. The data may be there, but displaying it this way, to me, doesn't make the point.

Some questions. One is on the prescription figures, am I right in interpreting the numbers that there really are two trends? That there's a break point about the time that health care reform dropped off? It looks like prescription drug costs stayed about the same, either as a percentage of total or in raw numbers. And then about the last two years, '95 and '96, started going up rather rapidly. You might want to take a look at that, because if you look at it overall, you're saying prescription drugs

went up less rapidly than dental, which is a surprise given this population. But I think if you look at a break point there, there really were two different trends.

Why is the median so far from the mean?

DR. ZABINSKI: That's primarily -- you mean with the percentage of --

MR. MacBAIN: There's just a huge tail of people who pay 200 percent -- and specifically here. Not generally. That's not a philosophical question.

DR. ZABINSKI: It's primarily just due to the skewness. In a lot of cases, the medians are in a lot of cases --

MR. MacBAIN: You've got a lot of people who don't pay much and a few people who pay a lot.

DR. ZABINSKI: -- the lowest values that are there. It's just primarily due to the skewness.

MR. MacBAIN: It looks like in 1995 -- again, this is from a fairly cursory look at the numbers, but when you're displaying costs for people with versus without

supplemental coverage, it looks like those without supplemental paid less per year, which I would expect because they're not paying a supplemental premium. They probably don't have supplemental because they can't afford it, which means they also can't afford some of the non-Medicare services.

But in '95, that one year stands out, that your non-supplemental sample actually paid more which seems strange. I would expect some consistency across there. I don't know if you got an explanation. Or if you did, if it would lend any light to this, but I was just curious about it.

DR. ZABINSKI: At this time I don't have an explanation. I was wondering about that myself. I'll look into it.

MR. MacBAIN: Finally, in all of this, I remember an earlier draft got a little bit philosophical about what does this say for Medicare as an insurance program. And for me, it would help tie this all together by drawing some

conclusions about this. Is Medicare good, bad, indifferent? Or if we don't want to use value-loaded words like that, can we at least say something about does this mean that Medicare is doing what it was intended to do?

DR. WILENSKY: Actually going to -- I want to start with that point, although I had a couple of other comments.

One of the issues that kept popping up as I was reading it was well, there was a reason we tried to pass catastrophic protection 10 years ago or more than 10 years ago, and earlier in the decade there is a budget neutral catastrophic proposal that was raised.

So I think that with regard to that part, where it comes up in the discussion repeatedly, I kept wanting to say yes, we don't have back end coverage. There ought to be at least some statement of Medicare was set up without this usual component of insurance provision. There have been several attempts or some attempts in the past to correct for that, because part of it is like well, it's obvious if you

have some people without catastrophic protection, you're going to have some people that will spend large sums.

So to put it in what was a more reasonable context, just given the political history of the issue of catastrophic coverage.

I had two other comments. When I looked at the table that showed the income distribution of managed care in individual purchase for 1996, while it was clear that the under $10,000 group were more likely to go into managed care as I had expected given other discussions, I actually looked at that table and thought, except for the lowest income and to a lesser extent the highest income, I was kind of struck that they didn't look very different in the middle. And that it was different from what I had expected, either in discussions with people from managed care or just my conventional wisdom about the subject.

Now I don't know whether you've actually -- if they're statistically significant differences or not, but the magnitude, whatever the statistical difference between

those two, the size of the difference is smaller.

DR. LAVE: What table are you looking at?

DR. WILENSKY: Table 15 where we look at the income distribution of managed care and individual purchase beneficiaries. As I say, I was struck that the -- there's no question the under $10,000, that's sort of a difference worth noting.

And slightly somewhat in that vein but not quite, the highest income. I was as much taken that it was closer to even distribution in between those than I would have expected.

DR. ZABINSKI: Just one thing. I ran a bunch of statistical tests and my memory's a little fuzzy on everything. But if my recollection is right, the only row there where there is a statistical difference is the under $10,000.

DR. WILENSKY: I think that's kind of worth mentioning. We keep hearing that this is primarily, or this is heavily dominated by people who are very low income, not

Medicaid but very low income, and the presumption is they have no effective choice or whatever.

I think the fact that there isn't much difference in the distribution, except for the -- is really worth nothing.

DR. NEWHOUSE: It's only a quarter.

DR. WILENSKY: It leads me to another thought that -- I don't want to have this as a -- I suspect other people might not agree with this -- as a definitive statement but as something that I think is at least an issue that we ought to raise. And that is in the discussions where you talk about the percent of income that people are spending out-of-pocket for uncovered services or for premiums, which is an important and interesting piece of information, it seems to me -- particularly because of the way I looked at this table, which was somewhat different, which is that yes, it's different for the very lowest income but otherwise it's not so different.

I found it would have been interesting for me to

have seen an additional table that looked at, or at least some additional estimates, that said how would it look if we separated out people who had an option to choose manage care but did not, versus people who did not have such an option.

Because part of what I am seeing as an economist is that when we look at the share of income or the amount of dollars that people are spending on uncovered, and we already know that managed care is the most cost effective strategy for minimizing that amount, what we are seeing in part is reflecting choice, proper choice but choice for those, at least, who have choice.

And so it's a really different issue and I think it was getting muddled up as to is Medicare doing what we wanted to do? I think people who chose not to go into managed care, who live in a county in which managed care is available -- and we can only approximate that -- are making a statement but it's very different in terms of uncovered Medicare or the amount spent on uncovered services or out-of-pocket for people who had no effective choice. Then you

really are looking at something that sounded like it was what was being looked at elsewhere.

Since the bulk of the people live in counties -- not all of them for sure -- but large numbers of people live in counties where there are managed care plans, that just strikes me as an additional piece of information that is worth nothing.

Again, I don't want to make it that this, in any way, implies that they should have been there, that they need to go into those kinds of plans, but it was an option they had available and so it makes the amount that they're spending on these uncovered Medicare services in a somewhat different context. It's reflecting a presumed choice as to not minimize the amount of money being spent on uncovered services.

DR. LAVE: I read this chapter and I thought it was interesting, but I also thought it would be helpful with some sort of a description about what we know about health care expenditures. And different ways that people look at

this, whether or not it should be a prepayment system, whether or not it's an insurance based system. Because to some extent people are shifting out risk and sometimes they aren't.

We do know that a very small proportion of people are going to be liable for a high proportion of expenditures. Now this is not the same thing as proportion of income, but it does have to do with the fact are you going to pay a high dollar level -- you're only going to pay a high dollar level if you're sick and only a small -- we know what the distribution of Medicare expenditures is.

I thought that to put that in there would at least give some balance.

Having said that, I was terribly surprised about a finding on the difference between the mean personal expenditures of people without beneficiary supplemental coverage. For instance, not surprisingly that people without supplemental coverage paid less out-of-pocket on average, because they are not paying for the supplemental

and a lot of them -- and their medians would even be lower.

But I was terribly surprised that at the 95th percentile that they paid more out-of-pocket. That didn't make sense to me, because it seemed to me that -- less out-of-pocket. The 95th percentile for everybody is $4,745 and for those without supplemental coverage it's $4,426. That I found very surprising because surely one would think that it should have been higher.

So I'm curious then about the numbers. I don't know about anybody else, but that just flies contrary to what we would have thought that insurance would do for you at the upper end. So the mean numbers make sense. The 95th percentile number does not make sense. And I think that it would be worthwhile if you reflected on this.

DR. KEMPER: Great selection.

DR. LAVE: But you have to be real select in order to get it at the 95th percentile. The mean you can understand, but the 95th percentile, it does say something about selection, but it's so far off my prior that I'd like

to think about your commenting on it.

DR. ROSS: That's not true in every year though.

DR. LAVE: I think I looked at every year and it's close on every year. It is lower, with the exception of '94 it is -- well, no, you're right. It could be a small number problem, that you don't have enough numbers to get sort of--

DR. ROSS: What you might see is that small tail of people with very high costs is moving right around that percentile cutoff.

DR. LAVE: Yes, but I think you should look at it. It could be a small number -- 5 percent of 1,000 isn't very much, but that's really the number that, in fact, one wants to look at for the uncovered people, is what happens to people who, in fact, are unlucky because the mean and the median are different.

I also wonder whether or not it makes sense to pull out the Medicaid population and deal with them separately. The reason for that is that the Medicaid population is really a very different population and, by and

large, under the Medicaid program we have agreed in society to pay for almost 100 percent for all of the costs that you have here. So one would expect to see that the supplemental payments are zero.

I just sort of think that you learn a little less by keeping in that population, in terms of what's happening to the average Medicare population. I find it very hard to make sense of average out-of-pocket payments in a program where every individual is subject to such different sets of rules about how the access --

DR. NEWHOUSE: It's analogous to computing the uninsured on the under-65.

DR. LAVE: I think you should create the uninsured on the under-65. It doesn't make any sense to me to include the over-65 in a calculation on the uninsured population of the United States. I just disagree, but it seems to me that we're trying to find out what Medicare means, to some extent, and we have a population where we're covering 100 percent of most of these services for people. So that

doesn't really tell me, for people who are --

DR. NEWHOUSE: I think it depends on whether your question is Medicare or the panoply of Federal programs.

DR. WILENSKY: I really don't agree. I mean, it obviously depends on what question you're asking, but you also have this problem that you don't know how much the employer is paying.

DR. LAVE: I think up front all of this there should be a much bigger description of the world as it faces these people.

DR. WILENSKY: I don't have any problem with that but --

DR. LAVE: Because people come into the situation with extraordinarily different claims on resources, both their own and other members of society's.

DR. WILENSKY: No, I think it's fine to comment on the difference, but I am very uneasy about excluding one group only when there are a lot of funny groups.

DR. KEMPER: A couple of methodological comments,

and then some substantive ones. On table 15, which Gail was talking about earlier, it might be useful to present the median income of people who are in managed care, compared with the median income of people not, just as a different statistic.

Secondly, on the dollar figures, are they adjusted for inflation?

DR. ZABINSKI: No.

DR. KEMPER: I wonder if it wouldn't be better to adjust them for inflation, so you could see what the dollar trends are.

DR. ZABINSKI: I want to make sure I'm understanding you exactly. Like I go through '92 through '96 and just to adjust the '96 back to '92, for example?

DR. KEMPER: So it's in constant dollars.

DR. NEWHOUSE: Which table are you talking about? Oh, just the various --

DR. KEMPER: Basically any time trend that's in dollars.

DR. NEWHOUSE: Absolute dollars.

DR. KEMPER: Yes, I would think the CPI because this is a consumer expenditure. And if health care's going up then --

DR. WILENSKY: That's fine except as it happens that was a very low inflation period. It's more accurate.

DR. KEMPER: If it doesn't make any difference.

DR. WILENSKY: If you can do easily, it does make it a better number.

MS. ROSENBLATT: I say each of these categories should have a different number, so I think we're better of not having any [inaudible]. Dental [inaudible] very differently medical, for example. Drugs [inaudible] differently.

DR. KEMPER: But this is the consumer perspective. Out of my pocket what did I pay.

DR. NEWHOUSE: We're not trying to measure the real quantity of drugs or whatever, which is what your number would do. We're trying to measure some kind of

burden on the consumer.

MS. ROSENBLATT: I'm just saying, I mean that's the same --

DR. ROSS: The average incomes are going up at the same rate as the CPI for this population.

DR. WILENSKY: Those who are on Social Security are.

DR. ROSS: We'll look into it.

DR. KEMPER: On Joe's comment about how to deal with two-person households, I was comfortable with dividing by two, but if it isn't quite right I would rather go to putting the couples together and combining the income and combining the expenditures, so that you look at the sort --

DR. ZABINSKI: You can't do that. That's not possible. They have individual expenditure data and they have the joint income for the couple, but they don't have the expenditures for the other person in the couple.

DR. KEMPER: Okay. On the substantive side, I

thought the persistence analysis was really interesting. A surprising amount of persistence, at least to me.

I would think it would be useful to add a table that looked at the percent of income by what quartile people were in, so that you also look at the out-of-pocket shares, as well as just for dollars. And I guess the question is whether or not the high expenditure group -- there's a group of people with a persistently high share of expenditures over a four year period.

I guess another question or thing to think about is what's the relationship between this work and the June report on prescription drug benefit? That some of the numbers here really ought to feed into that prescription drug and kind of set up that work.

And then finally, you talked a little bit about the effects of the BBA on the out-of-pocket expenditures of people enrolled in managed care Medicare+Choice. It seems to me by now we ought to have some idea of what the benefit package numbers look like and what the premium numbers look

like, to be able to come up with a rough estimate of sort of the magnitude of that effect on out-of-pocket costs.

And that if you can do that, that would call more attention to that result because I don't know how big it is but right now you show fairly substantial difference, and that could be diminishing. And for once we would be actually ahead of the data instead of several years behind.

MS. ROSENBLATT: Just to pick up on that, if you can't, because I think that's a good idea to make some kind of statement. If you can't quantify it, you might at least be able to make a qualitative statement like X number of plans withdrew the drug benefit and Y number of plans increased copays. Just some statement to help point the direction.

You do say it's likely that that will happen, but if we could make it more specific, that would be great.

I thought this was a terrific chapter and I really thought all of the numbers that people have been talking about, the fact that they're all there and they're giving us

results that are, in some instances, different than what we expected, I think it's just providing a lot of value.

I have a couple of questions, and I'm sorry if these were mentioned before, I had to miss part of the discussion. You mentioned, when you were comparing managed care enrollees to indemnity, that you adjusted for age and sex. Could you just explain how you did that?

DR. ZABINSKI: I divided each of the two populations into 12 age-sex categories and then I took the sampling weights for the people in managed care and adjusted them so that the percentage of the people in managed care from each cell is equal to the percentage of the analogous cell for Medigap.

The idea is say before adjusting for age and sex, for females who are 65 to 69, suppose they're 10 percent of the managed care population. And suppose that analogous population is 12 percent of the Medigap population. Well, I adjusted the weights of the people in that cell for the managed care so that their weights add up so that they're 12

percent of the managed care population.

MS. ROSENBLATT: Thank you. I know when I spoke to you this morning, you said you were trying to cut it back and we're all telling you things to add. But somebody else may have asked for that.

I thought, as you were focusing in on a couple of groups like the group over 85 and the low income group, that it would be helpful to have a background chart of what percent of all the beneficiaries that you're looking at did each of those categories represent.

The other thing is somewhere in the paper you've got a list of the BBA impacts on the managed care plans, and you might also want to mention the weighting between the regional and the national. You didn't get that in your list.

I just want to pick up on something that Peter said. As I was looking at the outline, in terms of doing away with the silos and sort of unifying it, I think a lot of the stuff in this chapter can help unify the managed care

program and the fee-for-service program and might help in some introductory paragraphs in the paper.

Another question on Judy's 95 percent question, the category without supplemental coverage, I just want to double check. Those are definitely people without coverage? Or just people who don't pay a premium for that coverage?

DR. ZABINSKI: My understanding is that they don't have coverage. People that have zero premium appear, in the code book, they appear in the categories for Medigap and that sort of thing.

MS. ROSENBLATT: If the employer pays 100 percent of the premium for Medigap, then they would still show up as having supplemental coverage?

DR. ZABINSKI: Yes.

DR. NEWHOUSE: Any other comments?

DR. LAVE: I just have a question. Are these out-of-pocket payments or out-of-pocket liabilities?

DR. ZABINSKI: They're out-of-pocket payments.

DR. NEWHOUSE: Thanks, Dan. We're going to go on

now to a discussion on documentation guidelines for E&M and coding edits. Kevin and Susanne?

DR. LAVE: Can I come back to one other thing on this? I can't quite figure out how a family could pay 82 percent of its income on health care?

DR. NEWHOUSE: It had very low income, it wasn't on Medicare, and you divided by two to make it even lower.

DR. LAVE: Or they could be families?

DR. ROSS: They have assets.

DR. LAVE: They have assets.

DR. WEINRAUCH: Last September we presented the background relating to documentation guidelines for evaluation and management services and coding edits. At that time, the Commission said we should continue to pursue these topics further. Today we will present draft recommendations relating to these issues and we desire commission feedback on these recommendations.

E&M services refer to the cognitive services provided by physicians. They fall into multiple categories

such as office visits, hospital visits and consultations, and subcategories such as new versus established patients. Each subcategory is further classified into different levels, anywhere from three to five of them, with higher levels corresponding to a greater degree of total work and higher reimbursements.

For example, payments for new patient office visits range from $30 to $126 versus office consultations which range from $45 to $182. Approximately 40 percent of Medicare expenditures to physicians were for E&M services in 1997. Shifts toward higher level codes from 1993 through 1997 for high volume E&M services occurred, the coding intensity decreased in 1998.

The change in coding intensity occurred simultaneous with other factors, such as anti-fraud and abuse initiatives and the results of the CFO audit in fiscal year 1996 which cited poor documentation as a source of improper Medicare payments. These results prompted the beginning of random audits. Currently .01 percent of all

claims of every carrier in FI are randomly audited. Or the change in trend could just be a one year aberration.

For example, here we see the distribution of hospital inpatient E&M services by code and over time. We can see that the percent of lower level codes are decreasing as the total percent of claims paid with an increase in the higher level codes over time. Except between 1997 and 1998 there is a reversal in this trend.

DR. ROWE: Now these are hospital inpatient, but these are still physician Part B expenditures, right?

DR. WEINRAUCH: Right. These are E&M.

DR. NEWHOUSE: These are the CPT or the HCPC codes.

DR. WEINRAUCH: We have the high volume E&M services and the annual change in average coding intensity. For every year between 1993 and 1997, there was an increase in coding intensity across all of these categories. But between 1997 and '98, with the exception of one category, there was a reversal of this trend and the change was

negative.

Documentation guidelines for E&M services specify elements to be included in the medical record in order to justify the level of service billed to Medicare. They are used by physicians to justify the level of services and by Medicare contractors to review submitted claims and during random audits.

HCFA introduced the first set of documentation guidelines in 1995 which were later revised in '97. HCFA proposed newer guidelines in '98 but these were found to be two complex in practice. Final implementation was postponed pending further consideration and pilot testing. HCFA plans to develop the pilot test in 2000 for the newer guidelines and possibly for alternatives to the guidelines.

HCFA should continue to work with the medical community in developing E&M guidelines and exploring the evaluation of alternative approaches to promote accurate coding of E&M services. In the past the AMA CPT panel provided input to HCFA with respect to the development of

documentation guidelines. In June of this year the CPT panel submitted the recommendations.

Other alternatives currently under consideration include focused peer reviews on statistical outliers and the use of time as part of the documentation process.

HCFA should pilot test E&M guidelines before their implementation and/or pilot test any alternative method. HCFA should continue to work with the medical community in the development of the pilot test and should ensure adequate time for physician education. Past experience has shown the complexity of the guidelines and the need for adequate physician training as to their use. The pilot test must be thorough and encompass a range of issues.

Coding edits are used by Medicare carriers during plan's review to detect improperly coded claims. The issue is whether or not to disclose these edits. Coding edits enforce Medicare coverage policy, which is not secret, and it is only fair to disclose them. Further, there are carrier specific edits.

On the other hand, disclosure could potentially stifle innovation. Also, once the rules are disclosed, people could potentially game the system.

On balance, HCFA should disclose coding edits to physicians and should seek review of the appropriateness of those edits by the medical community. Both of HCFA's contracts with Administar, which is responsible for the CCI edits which are open to the public, and the contract with HBOC which is responsible for the COTS edits, and which are proprietary. Both of these contracts expire October of 2000.

The HCFA Administrator has claimed that future contracts will not contain non-disclosure provisions. They say that the issue of whether or not the edits should remain proprietary will be an important factor in future contracts.

DR. NEWHOUSE: Maybe I should let my physician colleagues go first. Go ahead, Jack.

DR. ROWE: I just think it's interesting to observe that, in addition to having the E&M codes for the

Part B services decline, at this same time the case-mix indices in the hospitals declined. There has been a decline, certain in '99 I think it experiences a decline. And I think it declined in '98, as well, which may be why Medicare payments overall are down.

I think that gives, unless we have a healthier population which would be a nice thing to think about some day...

DR. NEWHOUSE: Successful aging, it's the effect of that.

DR. ROWE: But it does suggest that there's some secular effect here which might be fraud and abuse activities and the concern, or the more rigor that institutions are having with respect to coding and what have you, for both the inpatient and the outpatient.

I just think it might be worth, in the chapter, relating some of these changes that you see to the case-mix index changes and if, in fact, you could even do an analysis which would be really neat of looking at the distribution of

the change in case-mix index and finding those institutions that have like the biggest reductions or something, and see if those are also the institutions for which the greatest reductions in the E&M coding. That would be kind of a mini-analysis that would support the hypothesis that the Secretary is always talking about, about taking credit for this because it's a correction of what was grade inflation, if you will, or coding inflation, which may be the case.

So I think I would just --

DR. NEWHOUSE: Can you link the Part B claims to an institution in that way?

DR. ROWE: I don't know.

DR. NEWHOUSE: I wouldn't have thought so, but maybe so.

DR. ROWE: If the data are available, you can. These are inpatient claims.

DR. NEWHOUSE: But they're coming from the physician.

DR. ROWE: I understand, but they're in the same

facility.

DR. NEWHOUSE: In the teaching hospital case, I can understand how you might do it, but in general I would think it would be hard.

DR. ROWE: Well, I don't know.

DR. NEWHOUSE: You can. Lu tells me you can. Good, that's a good suggestion.

MS. ZAWISTOWICH: HCFA did it in the Centers of Excellence projects.

DR. ROWE: I think it would be interesting.

DR. WILENSKY: I agree. I think that would inform us.

DR. LEWERS: Gail, the other thing that came in about that same time were observation codes. I think that was '93, that they began coming in and into effect? So the impact there would, I think, impact probably both A and B. I think it's another area, an explanation we ought to, in all fairness, talk about.

MR. SHEA: Can you explain edits? I don't

understand.

DR. WEINRAUCH: Yes. It's a screening of what's appropriate and what's not. For instance, you wouldn't expect someone to have heart bypass and a cataract operation at the same time. So when there's a mismatch with diagnosis and procedure...

MR. SHEA: It might be worth a little bit more, sort of spelling out.

DR. NEWHOUSE: I have one substantive comment and one editorial comment. Right before the draft recommendation on pilot testing and all there's some text that says the Commission believes that alternatives to random audit should be explored.

Now my criminal justice colleagues tell me that the first principle of fraud control is that every claim has some probability of being audited. This is the principle of the IRS in auditing tax returns. And so I'm not persuaded that alternatives to random audits should be explored.

DR. ROSS: How about stratified?

DR. NEWHOUSE: No, that's fine. As I say, the principle is that there's no -- every claim has some positive probability of an audit. It might be a small probability but...

DR. ROWE: But an alternative to random audits would be auditing everybody, would be an alternative to random audits and would, in fact, not be a problem, according to --

DR. KEMPER: Joe would call that random audit with 100 percent probability.

[Laughter.]

DR. NEWHOUSE: I didn't think this remark would make me popular in certain constituencies.

This is just a remark on the organization of the text, on the COTS edits. I went through this about a page discussion of COTS and then at the very last sentence, you told me oh, by the way, they cost money, too. I'd put that first.

I think after that, it's sort of case closed.

MR. MacBAIN: A couple comments. One is on the edits. I definitely agree with the recommendation that's in here based on the notion that the goal in this program is to get accurate billing, not to catch people. From a programmatic standpoint, as opposed to from a proprietary standpoint it seems to me the only reason for keeping the edits covert is to catch people. And it becomes a game and I think we should stay away from that.

On the E&M guidelines, you say in the paper the Commission is not in a position to make recommendations on the content and then go on to essentially say HCFA ought to keep doing what they're doing in talking with physicians.

I think we probably know enough to provide some direction toward simplicity, make some sort of statement that if the guidelines are too complex to be applied, then they're no good. The utility is inversely proportional to the complexity or something like that. Provide some direction.

DR. LEWERS: Can you say that again, Bill? I'm

not sure I heard all or followed all of that.

MR. MacBAIN: My point is that rather than simply say HCFA ought to keep talking to doctors about the guidelines, to provide some direction that the guidelines should be simplified.

DR. LEWERS: They've heard that before.

MR. MacBAIN: I know. We've probably said it before, but I think it's something that stands repeating.

DR. LOOP: Time away from patient are.

Just for my own education, does the inspector general and HCFA, are their definitions of fraud in this regard, is that the same? The IG and HCFA, do they have the same definitions of fraud?

DR. ROWE: This is the HCFA IG. The HHS IG.

DR. WILENSKY: No, there should be no presumption in any of the departments that the inspectors general assigned to those departments and the departments agencies responsible agree on issues of where the problems are because they go through different reporting.

So that the inspector general is an appointee that is independent of the Secretary.

DR. LOOP: So what's the answer?

DR. WILENSKY: You ought not to assume that because it's not the HCFA IG, it's the HHS IG, or that the necessarily -- if you were to ask the inspector general what they're pursuing, it may be that they would both classify or label what they are trying to prevent as being the same, but there are frequently tensions between these two groups.

I don't know whether there's a definition.

DR. HAYES: I'm not aware of -- I don't think we've actually come across a definition. I mean, the only evidence we have of definitions is just what techniques the different entities use.

DR. WEINRAUCH: For instance, the Medicare integrity program would be a fraud and abuse initiative.

DR. WILENSKY: Any other comments?

DR. LEWERS: I'll give you some other general comments as we go along. I think there are a couple of

things, on page 5 talking about the guidelines and the concerns expressed, I think there's another major concern and that is what I call rigidity of specialty exams, the problems of codings, ER physicians having to do full physicals. They have a tough case in very critical situations, yet if they don't record breast exam and a patient has got abdominal injury. That sort of rigidity, the multi-specialty type of exam. I think we should put a third bullet in on that one.

Also, on age six you have a statement on the last part of it, as supported by the majority of specialties at a recent CPT advisory committee meeting. There was no formal vote on that, so that makes it imply that there was a vote and that that did occur. That did not occur. There was some sentiment expressed by some, but I don't think that we should say that that meeting had any special attention to that.

The other element along this same time, that needs to be looked in that same area, is the complexity of medical

decision making, which is another area that's being addressed, and we don't mention that. I think somewhere that should be in that same arena.

And I wondered whether you could tell me, on page seven, who Tillman is? I've been involved in this for a long time rather intimately, and read on it intimately, and I've never heard of --

DR. WEINRAUCH: He's a regional HCFA administrator in Kansas City.

DR. LEWERS: Thank you. I think some of the others I can just give you instead of taking the time at this point. In general, I agree with the recommendations that you talk about.

DR. WILENSKY: Any other comments? Kevin and Susanne, do you feel like you have enough guidance? Okay.

Single update mechanism.

DR. HAYES: Our discussion this afternoon on the single update mechanism is really a follow-up to the discussion we had at the November meeting where you talked

about a single update mechanism that would apply to physician services, hospital outpatient departments, and ambulatory surgical centers.

During the discussion there was a fair amount of consideration of this issue of substitution of services among settings and there were questions about the extent to which it occurs and whether it occurs between inpatient care and ambulatory care and whether there is evidence of substitution among the different ambulatory care settings.

So to move us further toward recommendations on this issue, staff analyzed physician claims data to try to look for some evidence of substitution. Essentially what we're doing here is relying on the fact that physicians provide services in multiple settings. And looking at physician claims data gives us a sense of just how much substitution is occurring.

So what I would like to do this afternoon is to just briefly summarize the results of the work that we did, and then to see if there can't be some discussion of the

implications of the results of our work for commission recommendations.

It would seem that, if we could just try to think about what this issue of substitution means for recommendations, first off, from what we can see it looks like there is a certain amount of substitution going on between inpatient care and ambulatory care, and that tends to reinforce then the commission's position that there be some consistency in updates across ambulatory care settings.

The other point to make is that there does seem to be some variability in substitution over time and across services between inpatient care and ambulatory care. That would argue for something other than a strict formula approach to the update mechanism, and rather we want to have perhaps some flexibility in the way this mechanism works in order to accommodate that variability in substitution of services.

So with that, let me just briefly summarize. What you talked about at the November meeting had to do with the

idea that this issue of substitution of services really applies regardless of the type of single update mechanism that you end up recommending. In the case of an update framework type approach, modeled after let's say the hospital update framework we have for inpatient hospital care, the issue of substitution is important. We'd want to attempt to measure the amount of substitution that's occurring from year to year. We would also want to try to analyze the effects of that substitution on the costs incurred by physicians and providers of ambulatory care services.

Alternatively, if the Commission ends up recommending an expenditure target approach for the single update mechanism, here again the substitution will be important. There what we would want to try to do is to anticipate the effects of substitution on expenditures and therefore on what type of target is adopted.

The other point that was made at the November meeting had to do with a potential problem with the

expenditure target approach. We would probably not want an expenditure target that applies to just one setting, that that could in turn trigger a kind of cycle, if you will, where we have say substitution into a particular setting, expenditures go up, exceed a target, payment rates are reduced, and then there is some substitution then away from the setting because of the payment rate reductions.

So that was viewed as an undesirable thing, of course.

Turning now to what we did to analyze substitution, let me point out first that we were aware of two different types of substitution that can occur. On the one hand, we can talk about substitution that's relatively straightforward, in that it involves just one service and it's a question of substitution of one setting for another. The example in the paper we cited had to do with cholecystectomy or removal of the gallbladder.

Here we see the emergence in recent years of laparoscopic procedures that permit delivery of

cholecystectomy on outpatient basis, and that seems to be substituting for what previously was done strictly on an inpatient basis.

The other type of substitution that we could talk about is a bit more subtle, and that has to do with substitution of one or more services for another service, and multiple settings could be involved. Here again, the example that we cite in the paper has to do with treatment of prostate enlargement. We find, in looking at claims data, that use of surgical procedures for treatment of prostate enlargement has gone down a fair amount during the past say seven to 10 years. And from what we can tell, that appears to be due to emergence of other treatment modalities for this condition, drugs and so on.

So to look at substitution with respect to that kind of situation, you would need a fair amount of clinical knowledge of what's going on with respect to particular conditions. You probably would need to analyze what goes on during particular episodes of care. Episodes of care is a

particular type of framework that's often used for this kind of an issue.

For purposes of this meeting, we were able to deal with the first type of substitution but not the second. Love to do that, I just haven't had the time to do so yet.

The next point I'd make about the analysis is that we looked at shares of expenditures for physician services by setting. We used physician claims data for five years, 1994 to 1998, and we interpreted changes in shares of expenditures by setting as substitution among settings.

So if we look now at a modification of a table that was in the paper for the meeting, this table addresses the issue of substitution between inpatient care and ambulatory care. So what we see here are shares of physician services expenditures in the ambulatory care setting. Looking at the first row of this table, you can see that the share of expenditures in an ambulatory care for consultations went from 37.9 percent in '94 up to 42.9 percent in '98, a change of five percentage points.

We also, in looking at this issue, tried to get a sense of whether the shift to ambulatory care was accelerating or decelerating. Let me define what we mean by this acceleration/deceleration business.

What we did simply was to say well, if the change from 1997 to 1998 in expenditure share was greater than the average change for the previous three years, then we called that acceleration. Simple approach to dealing with the issue, just trying to provide a sense of what's going on here. Perhaps some more sophisticated measure is possible.

DR. ROWE: Would you say that again, please?

DR. HAYES: Sure. Bear in mind that this is a summary version of the table in the paper, but if you had on this table a column for 1997 and looked at the change in share for '97 to '98, and compared that to the average annual change from '94 to '97, then you'd say well okay, if the most recent change is greater than the earlier average, then that's an accelerating shift to ambulatory care.

DR. ROWE: So you really can't look

at the data on this chart and determine whether acceleration or deceleration is correct because it's based on a comparison to '97?

DR. HAYES: That's right. I just didn't want to put too many columns on this table for purposes of this overhead, but the details is in the paper.

DR. ROWE: Can I ask another question about the rules here? I didn't understand.

How did you determine, just before you get to the analysis too much Kevin, the example you gave on prostate, you said there used to be a lot more prostate operations, that seems to be falling off. And you assumed that was a substitution and people were using drugs or other means, whatever those would be. I would be interested in knowing what those might be.

As far as drugs are concerned, my understanding is there is a drug for prostate enlargements, phenasteride, but I don't think it's widely used and not very effective. In fact, I think what happened is people found that you didn't

have to operate on these people, and that there is no substitution. In fact, it's a deletion.

So that we shouldn't assume that it's a substitution. In fact, what's happening is nothing. Watchful waiting is what's happening with people with prostate disease, as opposed to surgery.

Now how did you determine that it was, in fact, a substitution for site or type of treatment, as opposed to a deletion? Because we do, every once in a while, find out that some things aren't worth doing and we stop doing them.

DR. HAYES: I'm sorry, I probably did not make the point clearly enough. We were not able to address that more complex subtle form of substitution. All we were able to look at, for purposes of this table and for this meeting, was the more simple version of substitution, which is same service, one setting versus another.

So my cholecystectomy example is apropos here. That's the kind of substitution we were able to deal with here, but not the other, where there could be as you say

some deletion of services.

DR. LAVE: Would it be possible -- there is both substitution, deletion, and addition, where addition is again not necessarily a substitution of services but more of the same.

For instance, if I take diagnostic x-rays, I could perhaps not be shifting the x-ray from the inpatient to the outpatient for the same patient. I could just be deciding that I want to do more outpatient diagnostic x-rays. So it's not a substitution.

DR. HAYES: That's true.

DR. LAVE: Would it be possible -- would it make sense in terms of the substitution issue, although you can't get at the deletion issue, would be to get some sort of magnitude? Was there an increase in the overall magnitude that was more -- you know, that most of the increase -- whether or not you can get some sort of sense for whether or not you know that we cut into the inpatient base, I guess?

DR. HAYES: Right.

DR. ROWE: I think that that's -- if I can be consistent and pick on both your examples, the gallbladder as well as the prostate. I think that there is an addition rather than an substitution with respect to gallbladder. What happens in Medicare beneficiaries, when endoscopic cholecystectomy came along, is a lot of people who wouldn't have gotten the operation got it. The point was that an 80-year-old person, they have some symptoms, we think it's the gallbladder, they have heart disease and a bunch of other things. We wouldn't take the risk of doing a regular cholecystectomy, they'd be in the hospital a week with a high complication rate, et cetera.

But if you can do a laparoscopic cholecystectomy in 25 minutes in this person with very little risk, then it's probably worth it.

DR. NEWHOUSE: I think for the policy conclusion he wants to draw it doesn't matter.

DR. LAVE: I'm not sure that that's true.

DR. NEWHOUSE: He wants to get to the instability

of the unit price if you have a fixed pot and you have changes that you're not anticipating going in, whether it's coming from substitution or whether it's just people doing more because the clinical threshold is changing.

DR. ROWE: Maybe we shouldn't call it substitution then.

DR. NEWHOUSE: That's fair.

DR. HAYES: Maybe it should just be growth in expenditures in ambulatory care settings or something.

DR. ROWE: Or change.

DR. KEMPER: Kevin, in this analysis you've lumped together all ambulatory settings and said that there's a shift from inpatient to outpatient. And then you said that because there is a shift out of hospitals, that argues for a single expenditure cap or a single thing.

It seems to me, I would be interested in whether this substitution is predominantly to a single setting at one extreme or whether roughly it's across all settings. Because it seems to me if it were to a single setting, that

would be an argument against a single expenditure cap, or treating them together.

Because what that would mean, let's say it all went to the outpatient department. Then you would see a big increase in outpatient expenditures but you would adjust your payment across all three settings. So the shift to the patient department would mean physician payments would go down and ASC payments would go down.

DR. NEWHOUSE: Peter, with the pot you're in trouble with unanticipated changes. The only issue is what you're going to spread it over.

DR. KEMPER: There are two separate issues. One is what's the rate of growth of the pot, which this aggregate analysis shown here speaks to. But the other question is whether there ought to be a single pool. And that depends on where the shift is to, where this exogenous shift is going to, whether it's in a single service or all services.

DR. NEWHOUSE: I'm not persuaded of that, but

maybe we should let Kevin finish.

DR. HAYES: There's another slide here which addresses the issue of substitution among ambulatory care settings. So I think there's really two arguments that I'm trying to make here.

One is with respect to substitution of ambulatory care for inpatient care, there is some variability in that substitution which makes it difficult to design a single update mechanism to accommodate substitution. The other argument I'm making is that there is substitution among ambulatory care settings and that argues for a single update mechanism among those different settings.

DR. KEMPER: Right. And I'm just adding a third point which is that where the substitution from the hospital goes affects how you view this combined pot. That's not to take away from the other two points.

MR. MacBAIN: I just think it confuses the issue to try to talk about both of those in the same chapter, since we're not yet talking in the context of a single

update factor for inpatient and ambulatory.

When you lead with a table that shows the migration from inpatient to outpatient, wherever, and then use that to lead into a discussion of a single update for all outpatient, it's a non sequitur. I think it would be better to stick to the issue of movement around within that outpatient pot, and leave this for another chapter.

It raises a much more complex issue, I think a very important one, having to do with this movement from inpatient to outpatient. But that's another problem, other than the one that is the primary focus of this chapter.

DR. KEMPER: I don't agree with that at all. Because I think Kevin's point about the variability of what's coming in is quite important, in thinking about how to deal with the outpatient.

MR. MacBAIN: I think it is in terms of the impact of the expenditure target for all outpatient services. It's a problem with an expenditure target. Unless it covers all of Medicare, including Medicare+Choice, it's going to be

deficient to the extent that there's movement among the silos.

But that's different from saying let's take three of these smaller silos and lump them together. And you confound that argument with the other argument when you lead off by looking at more grain pouring into these silos.

DR. HAYES: Let's see, where are we? I think we've pretty much gone over things here. I'll go over this slide quickly.

This is the one that shows substitution among ambulatory care settings. What you see here are expenditure shares calculated strictly for the ambulatory care delivery of services and divided up among the alternative ambulatory care settings.

I should point out right away here that we're not saying here that these different ambulatory settings are complete substitutes for each other. They are not. There are some services that are only provided in hospital outpatient departments. The cholecystectomy example is one,

where patient safety considerations and other things dictate where the service is provided, and to date it's only provided in hospital outpatient departments.

Other services are only provided either in OPDs or ASCs, once again due primarily to patient safety considerations. Also bear in mind that with respect to ASCs there is a list of services that HCFA has approved for delivery in ASCs, and so there are some things that just aren't done in ASCs. The diagnostic services that you see on this table, echocardiograms and nuclear imaging, are examples of that.

That's pretty much it on this one, I guess.

So in conclusion then, putting aside Bill's important point for a moment, there is some evidence of substitution among ambulatory care settings and that would argue for some consistency in updates among ambulatory care settings, a position that the Commission has taken, I believe, in the past.

The other is this variability issue of

substitution between ambulatory care and inpatient care. It seems to be accelerating for some services, decelerating for others, and that would argue against a strict formula approach to the single update mechanism.

If we think about our alternatives, the update framework versus expenditure target approach, we could say that certainly with respect to the hospital update framework we don't have a strict formula there. We do look at this issue of substitution each year in setting the update, try to analyze what is influencing provider costs because of that substitution.

The question here is whether or not we can do that kind of an analysis for this group of services, this group of ambulatory care services.

The other side of it is the expenditure target approach, and there again the substitution would need to be considered in future years and anticipated for purposes of setting expenditure targets.

MR. MacBAIN: Is the conclusion of this then that

given all this variability we should be focusing or recommending that HCFA focus more on an update framework rather than an expenditure target or sustainable growth rate?

DR. HAYES: No, I don't come away with that conclusion. I mean, I don't know what the conclusion is really. You asked if the variability that we see, does that argue for an update framework for ambulatory care settings?

MR. MacBAIN: Yes. Suppose, for instance, that we recommended, or let's say it actually happened, that there were a sustainable growth rate approach for all ambulatory services, which still excludes the impacts of Medicare+Choice enrollment and migration from inpatient to outpatient and technological change and a few other things.

Does your analysis suggest that no matter how elegantly that thing is constructed that it would be deficient because of all of these other variables that are not included, to the extent that the program would be better served by an update framework approach?

DR. HAYES: I think what I'm saying here is that instead of developing an expenditure target approach that's a strict formula that includes enrollment changes and growth and real GDP per capita, and growth in input prices for the things that physicians use, that there needs to be more flexibility in that development of an expdenditure target.

MR. MacBAIN: So if we had a sustainable growth rate that applied to all ambulatory services, that that would change from year to year not on a formula driven basis related to the GDP, but rather on an update framework basis?

DR. HAYES: I don't know if it would need to be year to year, but it would need to be periodically revisited, I would say, just because --

MR. MacBAIN: We have to have something to report every March.

DR. LOOP: Kevin, is this movement or substitution, is this thought to be enhancing reimbursement or is this really progress in medicine that adds value to care? That's the first question.

The second one is that there seems to me, as a physician, that there's so many different dynamics in each of these sectors, you have different growth rates, different inflation rates, and there might be a link between the hospital outpatient department and the ambulatory surgery center, but certainly not the physician's office. Or at least I don't understand how that could be.

And so, I don't really see how you could capture one common factor in different fields that are in evolution. So I don't see how you can do this or why we should do this.

DR. HAYES: To try to answer your first question, you're asking whether the changes we see are driven by payment policy versus changes in medical practice. I would imagine it's probably both of those and maybe other things, too. I think it would be a pretty complex undertaking to try to explain why these changes are occurring.

DR. LOOP: I don't think the average doctor out there has a clue about what -- I mean, they're not moving people around to enhance reimbursement, I don't think. What

do you think, Jack? Oh, Jack's not there. Okay, Ted?

DR. LEWERS: There's been some concern in a couple specialties of moving because reimbursement is greater in one area than another and that was the reason that we discussed this whenever it was, a year or so ago, and sort of went for the single. But I'm beginning to move away from it. I don't think that's the right approach.

I think the gastroenterologists were the ones that were concerned primarily, because of some of the shifts they were seeing in some of their procedures, that they felt were not moving into the quality based system but more being moved by reimbursement.

But I don't know, I'm getting very confused by the data. I see stuff and bills came out with an update. I sort of lean in that direction, but I don't know how to do it. I'm not clear on this now. What you've done is confused me.

But I think you're arguing more against a single than you are for it.

DR. WILENSKY: He is.

DR. NEWHOUSE: No.

DR. LEWERS: That's what I heard him say. Against a single for a multiple structure of some type.

DR. HAYES: The rationale for a single update mechanism is that there is some substitution occurring among these ambulatory care settings, and we do see that.

The good example is cataract procedures. A very common procedure in both OPDs and ASCs, and it looks like the performance of cataract procedures in OPDs is going down, and the performance of them in ASCs is going up.

DR. WILENSKY: But I guess I read what you wrote it was, yes, there does appear to be substitution in some cases, but that because of the complexity of what you were reporting, that the notion of having a single update mechanism as a way to resolve this was not very promising.

I guess there is -- I mean, I think people understand that there's some substitution and cholecystectomy is certainly an obvious case, and cataract

also, but it was just much more complicated in the fact of where it's moving from and to, and the fact that there are things that you aren't capturing, and because some of the substitution is inpatient-outpatient as opposed to outpatient-ASC-physician's office. The question of what the right grouping is, where should the mechanism be, makes it very complicated.

So the bottom line of are we going to where we thought we were going or it sounded like we were recommending last spring, which is to have a single update for all ambulatory activities, I took the bottom line as not so fast.

DR. NEWHOUSE: I came to the opposite conclusion.

DR. LEWERS: But those examples, Joe, are technology advances directing that more than anything.

DR. LOOP: Procedural substitution is done for efficiency and safety.

DR. NEWHOUSE: I want to come back to your point, but the issue to me is given a sustainable growth rate

framework for Part B spending, is that best done as multiple pots or a single pot?

Now Kevin's issue, with the variability from inpatient to outpatient, raises the issue about should you have a sustainable growth rate at all framework, or should you do it all the way we do Part A? We can talk about that if we want to, but we were having a discussion about a single pot or a multiple pot within the framework of given that there was a sustainable growth rate mechanism in Part B, were we going to have sustainable growth rates or a sustainable growth rate?

The substitution there suggests that if we're going to have an SGR framework, it ought to be a single pot. At least that's what it suggests to me.

While I've got the floor let me say to Floyd, even if physicians weren't shifting patients, I think what exactly gets called an outpatient department and what gets called an office building could change.

And second, I think on the medical side it's very

plausible that you could shift here or there. I could say come back for your follow up visit, I'll see you at the hospital, or come back and I'll see you at my office over on bumpety-bump street.

DR. LOOP: I don't think that's a reasonable assumption.

DR. NEWHOUSE: If the payment differences got large enough -- well, it's a scenario. You may not buy that, but I would --

DR. LOOP: We're very insulated where I am.

DR. NEWHOUSE: I think the more significant point is any time I'm setting a pot of money and then I'm going to say all right, and if the volume goes up the unit price goes down, then I have unanticipated changes in volume, either way I'm going to drive my unit price around in unanticipated ways. And the smaller the domain into which I'm forcing this volume change, the more I'm going to have price fluctuate around, which I don't really want. I want some kind of more stable price.

That's the argument I take from the single pot.

DR. LOOP: I appreciate your argument, but the average physician out there doesn't understand those shifts. I don't believe they're reimbursement driven like that.

There may have been some --

DR. NEWHOUSE: But even if they don't suppose -- just take the examples of technological. For technological reasons we're shifting care out of the hospital to an outpatient basis. If that isn't anticipated -- there's nothing really in the sustainable growth rate mechanism to allow for that kind of shift. Sustainable growth rate is just basically the growth rate of the economy.

So as this happens, this drives down unit price. Now we could say well, we ought to make it sustainable growth rate plus something to allow for this, which is fine, but then still on a year to year basis we may be victims of random shifts that are greater or less than whatever factor it is we've built in.

DR. WILENSKY: Couldn't your alternative

suggestion be that we're uneasy enough about the sustainable growth rate on physician, don't add it to other places because it's too complicated and there is no single easy way to do it?

I took away -- politically we may or may not be able to do anything about the SGR on physicians, but I'm not sure I would not -- I don't see much to recommend going to two more silos.

DR. NEWHOUSE: Fine. You and I just started from two different places. I started with the assumption that there was a sustainable growth rate mechanism that had been postulated for outpatient department spending, and the only issue was whether that was going to be a separate sustainable growth rate or was going to be combined with physician.

But if you want to say well, that's off the table, we, in fact, don't need a sustainable growth rate.

DR. WILENSKY: I think that whether -- I looked at whether this was leading us as saying, we've had one

mechanism, of a sort, since the 1989 legislation, the volume performance standard and the sustainable growth.

We can debate about whether or not that was the best way to try to -- whether it would have been better to go back and do an update mechanism as we do in the inpatient. But there's a lot of argument for not promulgating that same mechanism in other ambulatory areas. It's very complicated. I think that's what people are comfortable with.

I think that that is as reasonable, that there is not something in place.

DR. NEWHOUSE: I agree with that.

DR. WILENSKY: And indicate that if in fact -- if the policy direction is to have sustainable growth rates in each of these areas, then not putting them together is probably the worst of all worlds. But I would think that what our first recommendation would be this is too complicated to just say go to a single rate and we are where we are with the physician world, we can have that debate,

just don't add it anymore. It's not as easy as it might have been.

That would be -- and I think that, unlike where I might have been last spring where it sounded somewhat more reasonable, I think that a lot of this information suggests that it's just much too complicated and the notion of having a single rate is really not a good idea, but probably better than having -- multiple rates on little pieces is the worst of all worlds, but we ought to say that, if we think that.

DR. KEMPER: I agree with what you just said, so we can cut the discussion short if there's general agreement about that.

I guess I thought this was really a nice analysis and the fact that it is generating both some rethinking of this, I think proves that point.

I just wanted to confirm that you are going forward to do some simulations of alternate scenarios next time?

DR. HAYES: That was the plan. I was assuming

that an expenditure target for all ambulatory care settings was still an option.

DR. KEMPER: We can make your work a lot easier? Is that what you're saying?

DR. HAYES: I need to reflect a little bit about what it would be I would be simulating.

DR. WILENSKY: I think you should do it. The reason is because I think this issue might come up again of having these silo expenditure targets and we need to have some thinking about why that's not a good idea, but the way to resolve that is not to go through the three separate versus one, but to keep these others out.

DR. KEMPER: I agree with that because what I think is going on is our heads is we're visualizing that simulation and saying that doesn't look very good. So if you actually do it, it will really bring the point home.

And as part of that, I hope one thing you'll simulate is a substantial upcoding, or at least one that's similar to what's been observed when other payment changes

have gone into effect within the outpatient sector, so that you can actually see what the effect of that would be on physician payments and ASC payments, because I think I would draw a distinction between an ongoing program where everything has kind of been the same for a while, in terms of payment policy, and one where there's a big change. And so you have a problem in that silo of upcoding and a big increase.

That's what I think this whole sustainable growth rate discussion is about, is to deal with that. But then when you extend that across a common pot, that's where you run into problems.

And I view the exogenous migration into a single setting similarly, that it makes that common pot a problem.

DR. HAYES: Common pot with a change in one silo within the pot, right?

DR. KEMPER: Right. And that's going to happen over --

DR. NEWHOUSE: It's worse with multiple pots.

DR. KEMPER: It could be worse with multiple pots. And that we can see with the simulations. But to me the need for flexibility takes me to where Gail was.

DR. LAVE: I agree with where we have gotten. I just have a couple of observations on the text.

One issue is that I do have problems with the substitution in the ambulatory care from the inpatient to the ambulatory because I think that there are two things that are going on, and the word substitution is not necessarily the correct word.

There certainly are places where we know there has been a substitution, like outpatient cataract, but I don't know for some of the examples that you have.

DR. NEWHOUSE: How about just differential growth?

DR. LAVE: No question with differential growth, but that's different than the term substitution.

The second thing I have is also a comment on terminology and that has to do -- I got terribly confused when you started talking about the update factor. What I

wasn't sure was whether or not, in fact, you were talking about a pricing scheme as we use in the inpatient side, or whether when you were thinking about an overall aggregate growth target on the outpatient side, you were thinking that there would be flexible components to it, like an adjustment for a shift.

And so the reason that I make that is that the inpatient side is really a per service payment in terms of the target. The outpatient is quite different.

When I listened to the conversation, I was confused about whether or not you were talking about flexibility in terms of a formulistic cap aggregates, or whether you were thinking that the right way to do was to set a per unit payment. I just was confused with that.

DR. NEWHOUSE: Flexibility can only be implemented ex post if it's unanticipated, and then you're really back to a per price scheme. It has that same effect.

DR. LAVE: That's true. But it's sort of how are you going to make that adjustment? I mean, I can have my

SGCG says I go up with A, B, C, and D. And what I thought we were saying was look, E, F, G, and H are very important. I had trouble with the discussion in making sure whether or not what you were defining as an approach was the same way as I was defining it, whether we're using the term similarly.

DR. HAYES: I will clarify that.

DR. WILENSKY: I feel like we've come closer to a consensus about where we want to go. Do you have enough information to help you?

DR. HAYES: Yes, thank you very much.

DR. WILENSKY: It was a good discussion, a very interesting paper.

Tim?

MR. GREENE: Good afternoon. It's good to see you again. I've been away for a while. I'll be discussing hospital capital payment today. I'll be beginning with a brief description of the system to review the things we talked about in September. Then I'll be presenting the

results of impact analysis. And finally, presenting recommendation alternatives, options.

Briefly, as you probably recall, Medicare uses a prospective payment system to pay hospitals for capital costs. A 10-year transition from regional cost payment to fully prospective capital payment ends in fiscal year 2001. So in fiscal year 2002, all hospitals will be paid based on Federal prospective rates.

At that point, PPS will be paying hospitals using two separate per discharge prospective rates. One is the standardized amount for operating expenses and the other is the standard Federal rate for capital expenses. This raises the possibility of simply combining operating capital payments to form a single prospective hospital payment rate.

To begin our brief review, operating capital payment systems are similar but different in important ways. This is a brief summary that you saw in September. Both, as I indicated, use standard Federal rates. On the operating side, there's a separate standardized amount for different

hospitals in different geographic areas.

But both systems apply adjustments to the standard rates to reflect differences between hospitals. Although most adjustments address similar issues, they generally differ in formulas and variables used. I'm not going to go through all of these but the DSH, IME, wage index, and so on are the ones that we talked about in the past that you're familiar with.

Just by way of example, in terms of how adjustments differ, both operating and capital payment systems have adjustments for disproportionate share hospitals. But they differ greatly. Both are driven by complex formulas and rules and thresholds and rules of all sorts that differ in each case, and both lead to different allocations, different hospitals eligible for payment, and so on.

Both hospital systems update payment rates from year to year. Payment update systems vary in a variety of ways. I'm not going to work through it, but most

importantly in the hospital market baskets used to adjust for price increases.

There's strong reasons for combining operating and capital rates into a single payment rate. First, this would provide consistency between the capital and operating IME and DSH payments, the most important adjustments that currently are designed for similar purposes but differ in so many ways.

Second, it would logically lead to a single update framework for all payments. And as commissioners noted in September, it would greatly simplify the payment system and reduce the effort and expense in maintaining PPS. Combining rates would, in many ways, amount to a cleanup action for the prospective payment system.

Combining payments could be done initially by setting a new Federal rate simply as the sum of the Federal operating standardized amounts and the standard Federal payment rate. Both are set in a per discharge basis. As I indicated earlier, there's a single standard Federal rate

and a number of standardized operating amounts. So you get a handful of geographically varying standard total rates.

If you went this direction you'd have to choose a new set of payment adjustments rather than simply stay with two, and presumably adopt a new update system.

Regardless of the arguments in favor of combining payments, it might not be desirable if we determined that there were unacceptable unintended consequences. At the September meeting, after we presented no review of the system and recommendation options, you were leaning towards the option of combining rates, but several commissioners expressed concern and expressed a desire to see impact estimates before we actually took a step in making a recommendation.

At this time, I'll present the impact estimates and I'll be presenting some recommendation language that you can consider for your March report.

We used the recently completed fiscal year 2000 PPS payment model to compare the rate of single rate system

to that of maintaining separate capital operating payment rates. We assume fiscal year 2000 payment rules prevail with the exception of what we're changing for purpose of the analysis, and we ignore other recommendations that you've made or are considering on medical education payments, DSH reforms, and so on.

Our simulations apply the operating disproportionate share adjustment formula to both operating and capital payments, and we estimate a new IME adjustment for combined operating and capital payments and then apply that new adjustment to both operating and capital payments in the simulations.

Finally and importantly, remember that a policy of combining operating and capital payments is not intended to either increase or decrease total payments, so we conduct the analysis holding payment budget neutral to what they would be under current law or current policy. In particular, we set total simulated IME payments equal to simulated payments under current policy, and secondly set

total DSH simulated payments to DSH payments under current policy, which logically implies that total payments are the same as they would be under current policy.

Now turning to results, the changes in total payments, operating and capital payments combined, are very small when two payments are merged together. Note, by the way, though it's hard to get used to, the table is, as it says, presented in percentage points so that .07 is 7/100ths of a percent. As you can see, the impacts are very, very small. Zero at the all hospital level by construction, and then very small for each individual class of hospitals.

When the operating DSH and new IME adjustments are applied, there is almost no change at virtually all groups. All major classes of hospitals have changes in total payments no greater than 1/10 of one percentage points, and in some cases as small as 1/100th of a percent.

These results hold when we looked at other groups other than the ones I'll be displaying here. We looked at disproportionate share hospitals alone, disproportionate and

IME hospitals, hospitals by census division, and so on, and found consistent results across the board.

I also have a table which I'll pass, but I think it's in your mailing material, presenting results by control, proprietary, non-profit, and so on. I think we can just skip that. We've got enough here, and the results are pretty much the same.

We also looked at distributional results and found that these very minor changes are consistent within groups. We looked at percentiles of hospitals ranked by amount of change within each group, rural and so on, and compared the first and 99th percentiles to get extreme values. For major classes of hospitals that would be looking here, we see very, very little change, even at these extremes.

In all but one case the first percentile is greater than minus 1 percent and the 99th is less than 1 percent. That is 1 percent of hospitals with the greatest payments decline less than 1 percent. And comparably, those at the other end, payments increase on average less than 1

percent. We haven't looked at the minimums and maximums, but this tells us the overall picture.

The sole exception here is the first percentile for major teaching hospitals, but that means a 3 percent decline for three teaching hospitals in the country, if that. And even there, you've got to ask whether it means anything, in terms of the data. But if that's the extreme and unlikely case.

It may also be the result of the fact, as I say, we changed the teaching adjustment we applied in the simulation, so this is not just changing from operating to operating and capital combined, but it's making a small change in the teaching factor. So even that may be a result more of that modeling change than of any operating and capital issue.

Moving on, the Commission can recommend that Congress combine operating and capital payments into a single prospective rate. Or you could recommend making no change and continuing payment as it's currently done.

Combining payments would not be intended to increase or decrease total payments, as indicated earlier in the modeling discussion.

You could recommend that Congress combine operating and capital payments into a single prospective hospital payment system. If you did so, you could also note in discussion language or otherwise that if other major changes are made in the PPS, a combination such as this could be undertaken at the time of those other changes, but you wouldn't necessarily make a recommended change contingent on other actions being taken.

If you make such a recommendation, we'll prepare formal recommendation and discussion language to bring back to your January meeting that you can consider and revise at that time.

MR. MacBAIN: The only thing I'm concerned about is if in fact it does some real harm, it strikes me that this is essentially a housekeeping arrangement. We wouldn't, for the sake of tidiness, want to do some damage.

If three hospitals are going to take a 3 percent hit to their Medicare payment, that's potentially doing some damage. So I'd feel more comfortable with this if we could couch this in some terms that would provide some protection, so that the end result was really insignificant to everybody.

And also, it would be helpful to see some dollars. The percentages are comfortingly small in most cases, but even a very small percentage applied to something as large as Medicare still could be moving a lot of dollars around.

MR. GREENE: It's $60 billion of PPS payments, so you can work back from there.

MR. SHEA: Did you attempt any downside analysis here? How would this change things administratively for institutions? Much of any way?

MR. GREENE: I don't think so. It would change the bookkeeping, I suppose, but I don't think -- it might simplify, I suppose, some of the capital recordkeeping.

MR. SHEA: That's why I asked if you'd done a

downside analysis, because it seems like just in the unintended world, you know, somebody said oh this is a great idea, except I just had to change our computers. Maybe it's easy, but -- and I don't think the answer to this is there would be a big problem.

MR. GREENE: I don't think so. Early on in the system there was special recordkeeping reporting for old capital, new capital, and so on. I think that's a thing of the past now.

DR. WILENSKY: It is the intent, when this was adopted, since it was a struggle in the 1980s and then was put into effect when I was at HCFA, it was the presumption that after you went through this long 10-year phase-in, that that was the next step. Now it doesn't mean that it either has to happen or it has to happen right away, but the presumption was that once you got both systems fully into a prospective payment, that you would have a single payment.

I think that the issue of the amount of dollars and whether there is a hit, and then if there is a hit what

it would take to phase in so that you at least mitigate any big change to whatever hospitals might be adversely affected, would be useful.

DR. KEMPER: What about putting just a 1 percent limit on it?

DR. LAVE: My sense in just looking at these numbers are that this is probably the cheapest cleanup action that Medicare is going to ever have the opportunity of doing, and that sort of the concept of having these different definitions of everything floating out there just strikes me as being ridiculous.

DR. WILENSKY: It was definitely the intent.

DR. LAVE: To me the issue sort of says that the impact of doing this is very minor. There may want to be some modest payment for people with more than 1 percent, but I just think that to clean up the system, get rid of different recommendations, this is about as good as we're ever going to get, in terms of making a change that makes some degree of sense, in terms of structure of a payment.

I like the first recommendation that we go ahead kind of as scheduled, and maybe you want to have a small dollar transition.

But the idea of blending and that, I certainly don't think we want to do anything like that.

MR. GREENE: Just one point. It's abstract thinking and I can't show it with the numbers, but looking at that one minor hit, those three hospitals or whatever it is, we are also making changes in our assumed IME adjustment between the base case and the simulated capital payment system.

I suspect if there's any cause of that change in that group it may be that. And if that's the case, you can be concerned about those issues when we get to the DRG refinement or the other discussions.

DR. WILENSKY: As well we will. I think when we're talking about much more significant issues, like the DRG refinement and calculation --

DR. LAVE: There we're talking about real dollar

reallocations.

DR. WILENSKY: I think at that point we will do what would be normally, which is to either limit the amount of change in any one year as with the outpatient PPS or blend or something of the sort.

Why don't you, if there's any useful empirical work to show us next time, do it. But I mean, I would expect you to come back with a recommendation presuming we're going to go forward and make this recommendation as part of a report. If there's anything that you think is useful to share with us in January, that would be useful.

MR. GREENE: As far as the update process which we undertake about now, I assume we'll be either developing a single update or capital and operating --

DR. WILENSKY: Maybe for this year I think we would probably have to do separate, because this will take time.

MR. GREENE: I just wanted to run that by you.

DR. WILENSKY: Any further comments? Thank you,

Tim.

Let me open the discussion for public comment?

We will convene tomorrow at 9:00. Commissioners will be reconvening at 7:00 p.m. Tomorrow is a full and important day of discussion, so please be try to be sure that you will be here for the full morning and part afternoon. They were grouped together, relating to various aspects of payments, primarily to hospitals, and we wanted to have that go pretty much as a block, plus the ESRD report.

[Whereupon, at 4:33 p.m., the meeting was recessed, to reconvene at 9:00 a.m., Friday, December 10, 1999.]